

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral home, it should be detached for use on the death certificate. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Welfare prior to burial, cremation, or removal.

**IMPORTANT:** If Item 21 is marked or Item 18 indicates injury, or other traumatic event, the medical examiner

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 6 7 0  
REG. NO.

REG. NO

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Phebe Ellen Albaugh						9	1	82	9 A.M.				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Female		White		11	19	97	84			YRS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			Carroll		
9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Mt. Airy		Pleasant View Nsg Home						Housewife					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14. FATHER'S NAME FIRST Tilman		15. MOTHER'S MAIDEN NAME FIRST Alice		16. STREET ADDRESS 803 Lucabaugh Mill Rd.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. No		16c. WAR OR DATES 214-74-5345		17. INFORMANT		18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD.		DUE TO, OR AS A CONSEQUENCE OF (c) Advanced age group.											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Her age.													
20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/12, 1982, to 7/1, 1982, that (I) (we) last saw the deceased alive on 8/31, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		22c. DEGREE M.D.				22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 7/1/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. Strahill NACEV		22e. ADDRESS Pleasant View Nursing Home											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 3, 1982		23c. NAME OF CEMETERY OR CREMATORIAL Haugh's Lutheran		23d. LOCATION CITY OR TOWN Ladiesburg Frederick		COUNTRY Md.		24. FUNERAL DIRECTOR NAME Phebe Fletcher			
25. DATE REC'D. BY REC'D. BY RECEIVED Westminster, Md. 2157		26. DATE REC'D. BY REC'D. BY RECEIVED Sept. 7, 1982											

BP \_\_\_\_\_

note

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 3 6 7 1					
1. FOR STATE REGISTRAR										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
CLIFTON SAMUEL BLACKSTEN						Sept. 16, 1982						0945 M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
M		W		JAN 27 1916			66			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
MARYLAND		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			CARROLL								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
WESTMINSTER		CARROLL CO HOSPITAL								MAINTENANCE					
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13b. COUNTY		13c. CITY OR TOWN		14d. INSIDE CITY LIMITS?		12b. KIND OF BUSINESS OR INDUSTRY					
12a. MARYLAND		13b. CARROLL		13c. MANCHESTER		14d. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS				ROADS DEPT			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAREN NAME		FIRST	MIDDLE	LAST	16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
CLARENCE				BLACKSTEN	DALLIE										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		22a. ADDRESS		22b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
NO		214-28-2134		ETHEL F. BLACKSTEN		22a. DEEP RUN RD MANCHESTER, MD		YES <input type="checkbox"/> NO <input type="checkbox"/>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)															
PART I. DEATH WAS CAUSED BY:															
IMMEDIATE CAUSE (a) <u>Progressive cerebrovascular insufficiency</u>															
4370															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
{ DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral atherosclerosis</u>															
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
<u>arterial nephrosclerosis</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
										YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED		(ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept 14</u> , 19 <u>82</u> , to <u>Sept 16</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Sept 16</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>John S. Harshey, md</u>															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								22c. DATE SIGNED					
John S. Harshey, md		8 Ancker St. Westminster, md.								9/16/82					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE				
BURIAL		SEPT 20-1982		LUTHERAN			UNIONTOWN		CARROLL		MD				
24. FUNERAL DIRECTOR NAME		ADDRESS								25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE	
D D Hartzler, New Windsor, Md										SEP 20 1982				John J. Cawley	
DHMH-16 50M 1/81 (VRA 15, 4)															



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 2 3 6 7 2	
											REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Emily			Louise	Brothers		Aug. 16, 1982						9:31p.m.	
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female			White		Month April Day 12, Year 1923		59			MONTHS 4	DAYS 4	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland			U.S.A.				Carroll County						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Westminster			Carroll Co. General Hospital		Housekeeper								
13a. STATE Maryland			13b. COUNTY Carroll	13c. CITY OR TOWN Westminster	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1144 Bloom Rd.						
14. FATHER'S NAME FIRST George			MIDDLE	LAST Fossett	15. MOTHER'S MAIDEN NAME FIRST Ella		MIDDLE	LAST Williams					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS					
no			219-12-0980		Willard E. Fossett, Same as #13e.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Cardiopulmonary Arrest.</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4960 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Chronic obstructive pulmonary disease</i>													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Endometrial carcinoma</i>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>Burrier Jr.</i>			DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	27. DATE SIGNED 8/17/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) N. J. Burrier, M.D.			22e. ADDRESS 1200 W. Old Liberty Rd.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-19-1982		23c. NAME OF CEMETERY OR CREMATORIAL Salem Cemetery		23d. LOCATION CITY OR TOWN		25a. DATE REC'D. BY REGISTRAR SEP 29 1982				
24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr. Sykesville, Md.			ADDRESS						25b. REGISTRAR'S SIGNATURE <i>John J. Cawley</i>				

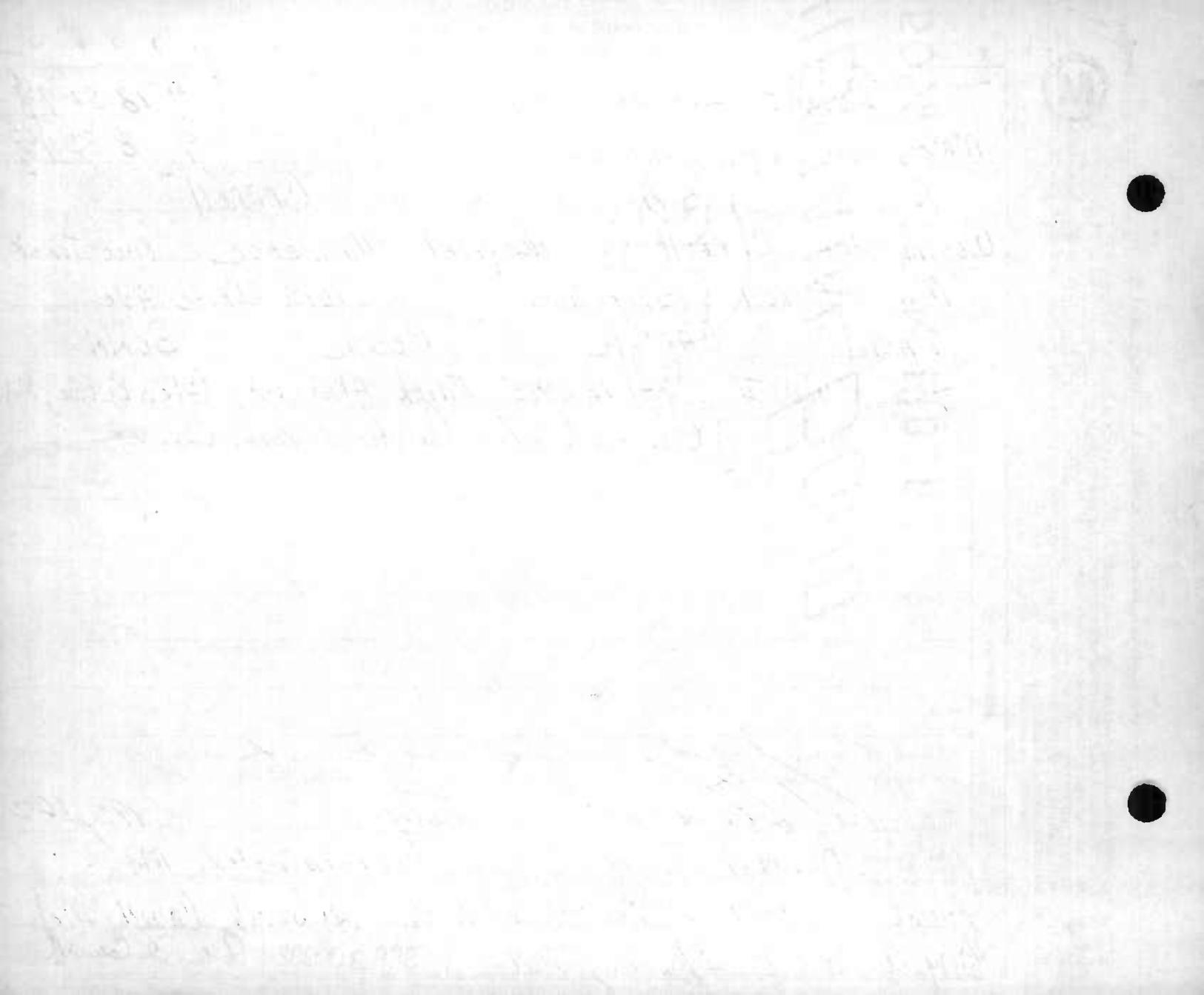


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONE, WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILE. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONE, WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILE. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONE, WITH FORM PM-3, RETAIN PAGE 5 FOR YOUR FILE. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201, PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2 2 3 6 7 3					
1- STATE REGISTRAR			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH 9 MONTH 9 DAY 18 YEAR 1882 7 105														
1. DECEASED NAME (TYPE OR PRINT)			FIRST Dwight JORDAN			MIDDLE			LAST Carlyle			2b. H. M.					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS MONTH DAY YEAR LAST BIRTHDAY)			7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.			8. IF UNDER 24 HRS.		
Male white			Male white			April 1, 1920			62 yrs.								
7b. BIRTHPLACE STATE OR FOREIGN COUNTRY			N.C.			7c. CITIZEN OF WHAT COUNTRY?			U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
10. CITY OR TOWN OF DEATH			Westminster			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			Carroll Co. Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE			Md. Carroll			13c. CITY OR TOWN			Sykesville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
14. FATHER'S NAME			David			15. MOTHER'S MIDDLE NAME			Carlyle			Bessie			Bunn		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			Yes WW II			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
						391 16 0785			Edith Akehurst			Glen Burnie, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) <u>Accelerated Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
22a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			22b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			22c. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
23a. I certify that I took charge of the remains described above, died on <u>Autopsy</u> <input type="checkbox"/> <u>Inspection</u> <input checked="" type="checkbox"/> <u>Inquiry</u> <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input type="checkbox"/> <u>Accident</u> <input type="checkbox"/> <u>Suicide</u> <input type="checkbox"/> <u>Homicide</u> <input type="checkbox"/> <u>Undetermined manner</u> <input type="checkbox"/>																	
ACTUAL SIGNATURE			Richard Jones			ADDRESS			TITLE (SPECIFY)			M.D. Deputy			MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT)			Richard Jones			ADDRESS									DATE SIGNED 1954/82		
23b. BURIAL, CREMATION, REMOVAL			23c. DATE			23d. NAME OF CEMETERY OR CREMATORIAL			23e. LOCATION CITY OR TOWN			23f. COUNTY			STATE		
Burial			9-21-82			New Oakland Cemetery			Sykesville			Carroll			Md.		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Harry W. Haight			Sykesville, Md.			SEP 20 1982			John G. Connelly								

BP

DHMH-17  
(VR A15 ME (5))  
15M 2/80

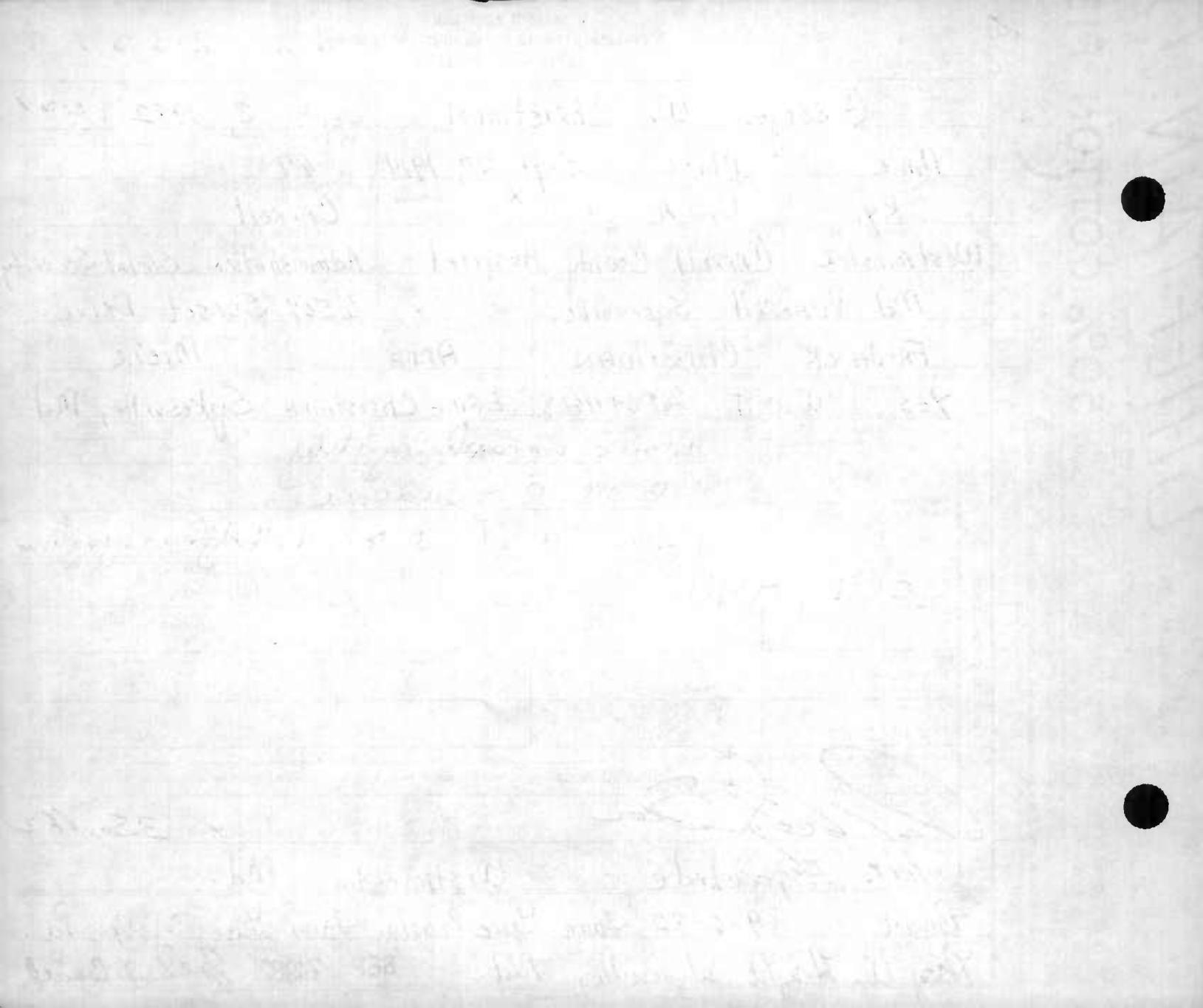


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IMPORTANT: If Item 18 shows any injury, or other traumatic event, the medical examiner must be notified or

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2	2 3 6 7 4					
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
George W. Christman												Sept. 3, 1982					8:30 AM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
Male			White			Sept. 27, 1914			67			MONTHS		DAYS		HOURS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
Ky.			U.S.A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Carroll									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Westminster			Carroll County Hospital			Administration			Social Security									
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS						
Md.			Carroll			Sykesville						6507 Sunset Drive						
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME												
FIRST			LAST			MIDDLE			LAST									
Frederick			Christman			Anna			Mieir									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS									
Yes			W W II			268 09 4608			ERNA Christman			Sykesville, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1: DEATH WAS CAUSED BY												ADDITIONAL INFORMATION RETRIBUTION, GRIEF, AND DEATH						
IMMEDIATE CAUSE (a) 2028 anoxic encephalopathy																		
DUE TO, OR AS A CONSEQUENCE OF (b) intestinal pneumonia																		
DUE TO, OR AS A CONSEQUENCE OF (c) diffuse well differentiated non-Hodgkin's lymphoma																		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
COLD, ASHD																		
21a. MEDICAL CERTIFICATION			21b. DATE OF OPERATION			21c. CONDITION FOR WHICH OPERATION WAS PERFORMED			21d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21e. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21f. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21g. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21h. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21i. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21j. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21l. LOCATION STREET			CITY OR TOWN			COUNTY STATE						
22a. I certify that (i) (the hospital) attended the deceased from now the deceased alive on above, (ii) (we) did not know the body after death.			22b. DATE			22c. DEGREE			22d. ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22e. DATE SIGNED 35/82						
			19			19			19									
22f. PHYSICIAN'S NAME (TYPE OR PRINT)			22g. ADDRESS															
Pack E. Perschade			Westminster, Md.															
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 9-6-82			23c. NAME OF CEMETERY OR CREMATORIAL Tawn Ave. Cemetery			23d. LOCATION CITY OR TOWN Tawn Ave. York Pa.									
24. FUNERAL DIRECTOR NAME Thay W. Hight			ADDRESS Sykesville, Md.			25a. DATE REC'D. BY REGISTRAR SEP 7 1982			25b. REC'D. TRANS SIGNATURE Joan G. Cawie									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2	2 3	6 7 5		
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
MARY			Susan			COOK			9 28 82			8	28	82	46	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
female			white			MONTH Aug DAY 11 YEAR 05			77			MONTHS	DAYS	HOURS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Md			USA						Carroll							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Westminster			Carroll Co. Gen. Hosp.									housewife			Home	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13e. STREET ADDRESS				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS							
Md		Carroll		Westminster		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			108 E. Main St.							
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME										
Charles			A Cook			Cordelia										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			21157				
no			n/a 213-18-8953			Jean Means			1518 Hughes Shop Rd. Westminster							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>myocardial infarction</u> <u>4100</u>																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																
DUE TO, OR AS A CONSEQUENCE OF (b) <u>atherosclerotic heart disease</u>																
DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1b: <u>recent (premises) myocardial infarction, hypertension</u>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20b. AUTO/ST?			21b. YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>							
21b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR. A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1c OR PART 2)										
			P.M.			19										
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>9/27 1982</u> to <u>9/28 1982</u> , that (I) (we) last saw the deceased alive on <u>9/28 1982</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED					
											9/28/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS										
Burial			10/1/82			Meadow Branch										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE			
Burial			10/1/82			Meadow Branch			Westminster			Carroll	Md			
24. FUNERAL DIRECTOR NAME						ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
PRITTS FUNERAL HOME						WESTMINSTER, MD			OCT 4 1982			John J. Coniff				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death.  
rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2	2 3 6 7 6		
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Odie SEREPTA DEll						Sept 25, 1982						1136 M	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR		2b. HOUR	
FEMALE			White			2 15 1909			73	IF UNDER 1 YEAR	IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Md			USA						Carroll				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Westminster			CARROLL County General						HOMEMAKER HOME				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Md			CARROLL			Finksburg			13e. STREET ADDRESS 2100 BETHEL Rd				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS				
GEORGE E Hughes			ODIE S Seppo			212-78-8695			Sterling DEll 18E 21048				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			16c. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a))				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
710 HOME			212-78-8695			Sterling DEll			Cardiovascular stroke				
4100			DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO, OR AS A CONSEQUENCE OF (c) atherosclerotic heart disease										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Sept 16, 1982, to Sept 25, 1982, that (I) (we) last saw the deceased alive on Sept 25, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) <input checked="" type="checkbox"/> not view the body after death.													
22b. SIGNATURE John S. Harshey, M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/25/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John S. Harshey, M.D.			22e. ADDRESS 8 Anchor St. Westminster, Md. 21157										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-28-82			23c. NAME OF CEMETERY OR CREMATORIAL BETHEL			23d. LOCATION CITY, OR TOWN Finksburg			STATE CARROLL	
24. FUNERAL DIRECTOR Robert Kyle Potts Jr.			ADDRESS Westminster, Md.			25a. DATE REC'D. BY REGISTRAR SEP 29 1982			25b. REGISTRAR'S SIGNATURE John J. Carroll				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the attending physician, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												82 23677					
												REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
Laura Naomi Derr						9-26-82					1530 M						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Female		White		MONTH 6 DAY 4 YEAR 1890			92 YRS.			MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			Carroll Co. MD.							
Maryland		USA															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Westminster		Carroll Co. Genl Hospit.			School teacher												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.		Carroll		Hampstead		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1130 Main Street									
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST	Shaffer							
		Samuel	J.	Derr			Elizabeth	A.									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		ADDRESS										
no		220-36-8224			Mr. Albion Parsons, Washington, D. C.												
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY												48 hours					
IMMEDIATE CAUSE (a) 4310																	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>After the stroke</i>																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE						
22a. I certify that (I) (this hospital) attended the deceased from 9/24/82 to 9/26/82, and that (I) (we) last saw the deceased alive on 9/26/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Lorraine M. Rogers</i> DEGREE MD												22c. DATE SIGNED 9/26					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)												ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial												23b. DATE 9-29-82		23c. NAME OF CEMETERY OR CREMATORIAL Hampstead Cemetery		23d. LOCATION CITY OR TOWN Hampstead Carroll COUNTY Md. STATE	
24. FUNERAL DIRECTOR NAME ADDRESS Eline Funeral Home, Hampstead, Md. 21074												25a. DATE REC'D. BY REGISTRAR SEP 20 1982		25b. REGISTRAR'S SIGNATURE <i>Janet C. Cawley</i>			

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM P.M. 3. RETAIN PAGES 3 OR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL/CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3 2 2 3 6 7 8				
1- STATE REGISTRAR		2. DECEASED NAME FIRST MIDDLE LAST										2e. DATE KNOWN OF DEATH ESTIMATED	2f. MONTH	2g. DAY	2h. YEAR	2i. PLACE
1. DECEASED NAME (TYPE OR PRINT)		Bak On Eng										<input type="checkbox"/>	9 8	82	46	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2e. DATE PRONOUNCED DEAD	2f. MONTH	2g. DAY	2h. YEAR	2i. PLACE						
Male	Chinese	May 11, 1902	80 yrs			9 8	82	78	10	Carroll County						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?										7c. BALTIMORE CITY OR COUNTY OF DEATH				
China		China										Carroll County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY
Sykesville		1040 Liberty Road										Owner				Dry Cleaner
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS								
Maryland		Carroll		Sykesville		YES <input type="checkbox"/> NO <input type="checkbox"/>		1040 Liberty Road - 21784								
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
Unknown		Unknown														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
No		063-24-3406A		Widow: Ruth Lee Eng, 1040 Liberty Road - 21784												
19. CAUSE OF DEATH (Enter only one cause per line. Item (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.												DUE TO, OR AS A CONSEQUENCE OF				
												(b) DUE TO, OR AS A CONSEQUENCE OF				
												(c)				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b):																
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										21c. AUTOPSY?				
												YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21e. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21f. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21 PART 1 OR PART 2)												
21g. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21h. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21i. LOCATION STREET		CITY OR TOWN		COUNTY		STATE						
22a. I certify that I took charge of the remains described above and held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <i>Richard A. Mowen</i> M.D.												22b. TITLE (SPECIFY) MEDICAL EXAMINER Carroll County Coroner, M.D. Richard A. Mowen, M.D.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 9/13/82		23c. NAME OF CEMETERY OR CREMATORIUM Lorraine Park Cemetery		23d. LOCATION CITY OR TOWN Woodlawn, Balto. Co., MD		23e. COUNTY		23f. STATE						
24. FUNERAL DIRECTOR NAME STEWART & MOWEN CO., 108 W. North Ave. Balto.		ADDRESS 21201		25a. DATE REC'D. BY REGISTRAR SEP 10 1982		25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>										
DHMH-17 (VR A15 ME (5)) 15M 2/80																



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director (see page 3) should be detached for use on the burial/tranit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial or cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or a physician should be consulted.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										82	23679	
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
BERTIE			A.	Farver		9/13/82		82	13	82	1445 M	
1. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		
FEMALE			White		MONTH	DAY	YEAR	90			IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Md			U.S.A.				Carroll			Home		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Westminster			Carroll Co. General		Home		Home					
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Md			Carroll		Westminster		YES <input checked="" type="checkbox"/>		205 Willis Street			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
			J.	Thomas	Farver	Rachel		3. Westmoreland St				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		18. IMMEDIATE CAUSE (a)			IMMED		
None			219-12-1994		Hazel Winter		CRADLAC ARREST					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY.			IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY INSUFFICIENCY		DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC CORONARY HEART DIS.			WEEKS YEARS		
4140												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.			AZOTEMIA									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN			COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from			19		74		to			9/13/82		
saw the deceased alive on			9/13/82		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.							
22b. SIGNATURE			DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. ADDRESS			22d. DATE SIGNED		
Robert J. Farver, M.D.										9/13/82		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN			COUNTY	STATE	
Burial			9-16-82		Westminster		Westminster Carroll			Carroll	Md	
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE									
Robert J. Farver, M.D.			SEP 20 1982									
15.4												



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 WITH FORM PM. 4 AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

ITEMS #18a-22a Film G572 10/11/82 STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 3 2 2 3 6 8 0																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST Raymond			MIDDLE Lee			LAST Ferguson, Jr			2a. DATE KNOWN OF EST. DEATH MATED	MONTH 9	DAY 9	YEAR 1982	2b. HOUR M													
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 6 - DAY 29 - YEAR 1917		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD		MONTH 9		DAY 9		YEAR 1982		2d. HOUR 1;10 PM									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) District Columbia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED WIDOWED		9. NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County				10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Armed Forces				12b. KIND OF BUSINESS OR INDUSTRY Gray							
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 202 E. Main St. Westminster				14. FATHER'S NAME FIRST Raymond MIDDLE Lee LAST Ferguson		15. MOTHER'S MAIDEN NAME Mary		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes				16b. SOCIAL SECURITY NO. Owl 22 579-03-7863		17. INFORMANT Frances Ferguson				18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of lung DUE TO, OR AS A CONSEQUENCE OF { Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22b. TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER																											
EXAMINER'S NAME (TYPE OR PRINT)		Hormez R. Guard, M.D.												ADDRESS 111 Penn Street, Balto., MD 21201		DATE SIGNED 9/10/82													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 5-14-82		23c. NAME OF CEMETERY OR CREMATORIAL FT Lincoln				23d. LOCATION CITY OR TOWN Bel Air		COUNTY Prince George's		STATE Md.																	
24. FUNERAL DIRECTOR Fletcher		25a. ADDRESS Westminster		25b. DATE REC'D. BY REGISTRAR SEP 14 1982				25b. REGISTRAR'S SIGNATURE George J. Conard																					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon original. Pages 1 and 2 should be filed within 72 hours after being detached for use on the Burial Transit Permit. Then please remove carbon original.

IMPORTANT: If Item 2 is marked or Item 18 above any injury, or other traumatic event, the medical examiner may be retained above.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 6 8 1

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Nellie W. Fleming						9-18-82				30 1 P.M.		
2. SEX		3. RACE		4. DATE OF BIRTH		5. AGE (IN YEARS LAST BIRTHDAY)		6. IF UNDER 1 YEAR		7. IF UNDER 24 HRS		
Female		Caucasian		MONTH	DAY	YEAR	99	MONTHS	YEARS	MONTHS	DAY	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		10b. KIND OF BUSINESS OR INDUSTRY		
Md. (U.S.A.)		U.S.A.				Carroll		Housewife		Home		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			12b. STREET ADDRESS			
Sykesville			Sykesville Elder Care			Md. Carroll			6330 Sykesville Rd.			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS		13f. ADDRESS		
Md.		Carroll		Eldersburg		YES <input type="checkbox"/>		6330 Sykesville Rd.		Dorscy		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT		
George					Walbert	Alberta		215-28-1624		A. Fred J. P. Sykesville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year									
4140			Cardiac failure, auricular fibrillation,									
DUE TO, OR AS A CONSEQUENCE OF (b) ASHD, multiple TIAs, uremia, diabetes												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			DUE TO, OR AS A CONSEQUENCE OF (c) mellitus									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20c. AUTOPSY?		20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (we) attended the deceased from 9-18-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		1962 19 to 9-18-1982										
22b. SIGNATURE Howard E. Hall		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9-20-82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard E. Hall, M.D., P.A.		22e. ADDRESS PO Box 318 Sykesville, Md. 21784										
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 9-21-82		23c. NAME OF CEMETERY OR CREMATORIAL Baltimore County		23d. LOCATION CITY OR TOWN Carroll		23e. COUNTY Carroll		23f. STATE Md.		
24. FUNERAL DIRECTOR NAME Harry W. Haight Sykesville, Md.		ADDRESS			25a. DATE REC'D. BY REGISTRAR SEP 20 1982			25b. REGISTRAR'S SIGNATURE John J. Coniglio				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then attach same to carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be informed of it.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2	2 3	6 8 2			
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		20. DATE OF DEATH		MONTH	DAY	YEAR	26. HOUR	
Irene B. Flohr									Sept. 21, 1982					4P.M.	
3. SEX			4. RACE		5. DATE OF BIRTH		16. AGE (IN YEARS LAST BIRTHDAY)		17. IF UNDER 1 YEAR		18. IF UNDER 24 HRS				
Female			White		Month Day Year June 21, 1921		61		MONTHS DAYS		HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH						
Pa.			U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		CARROLL		Sykesville						
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
801 Chapel Road				R.N. Nurse				Hospital							
13a. STATE Md.				13b. COUNTY CARROLL		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 801 Chapel Road					
14. FATHER'S NAME FIRST Amos				MIDDLE		LAST Booty		15. MOTHER'S MAIDEN NAME FIRST Anita		MIDDLE		LAST Ames			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS							
No				21334 7015		Myrl Flohr, Sr. Sykesville, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) METASTATIC CT TO BRAIN										1/2 YRS.					
1629 DUE TO, OR AS A CONSEQUENCE OF (b) BRONCHGENIC CT.										2 YRS.					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
DUE TO, OR AS A CONSEQUENCE OF (c) SMOKING CIGARETTES.										40 YRS.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/>			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)						21f. LOCATION STREET		CITY OR TOWN		COUNTY	STATE	
22a. I certify that (1) (this hospital) attended the deceased from <u>Sept 31</u> 19 <u>82</u> to <u>Sept 67</u> 19 <u>82</u> , to <u>Sept 67</u> , 19 <u>82</u> , that (1) (we) last saw the deceased alive on <u>Sept 31</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>R.V. Hough Jr.</u>														DEGREE MD.	
22c. PHYSICIAN'S NAME (TYPE OR PRINT)			22d. ADDRESS 6500 PANORAMA DR. SYKESVILLE MD 21784						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED 9-22-82				
23a. BURIAL, CREMATION, REMOVAL			23b. DATE 9-34-82		23c. NAME OF CEMETERY OR CREMATORIAL Springfield Cemetery		23d. LOCATION CITY OR TOWN Sykesville		COUNTY Carroll		STATE Md.				
24. FUNERAL DIRECTOR NAME Harry W. Hough			ADDRESS Sykesville, Md.		25a. DATE REC'D. BY REGISTRAR SEP 22, 1982		25b. REGISTRAR'S SIGNATURE Debra & Carol								



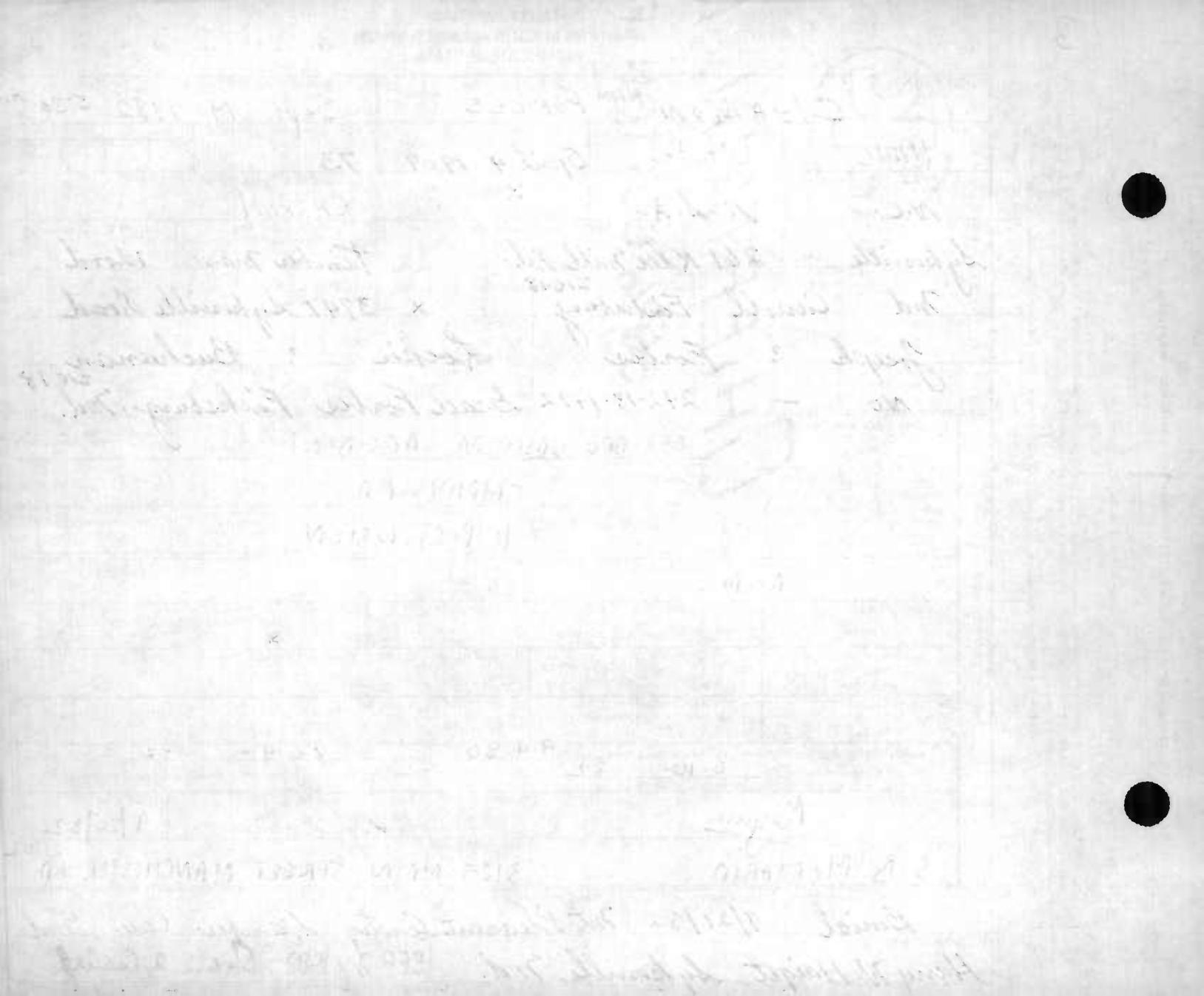
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8223683		
REG. NO.												
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Clemon NMN Forbes						Sept. 19, 1982			5:30 A.M.			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			
Male			White			Month Day Year April 4 1909			If under 1 year Months Days			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			7c. DATE OF DEATH YRS.			
N.C.			U.S.A.						9 BALTIMORE CITY OR COUNTY OF DEATH CARROLL			
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Md Carroll			361 Klein Mill Rd.			Timber man			Wood			
13a. STATE Md			13b. COUNTY Carroll			13c. CITY OR TOWN Finksburg			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
									13e. STREET ADDRESS 3947 Sykesville Road			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME Lockie			16a. WAS DEE RELEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)			16b. SOCIAL SECURITY NO.			
Joseph ? Forbes			Buchanan			No			242-18-1472			
									21048			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
4920 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any												
DUE TO, OR AS A CONSEQUENCE OF (b)												
DUE TO, OR AS A CONSEQUENCE OF (c)												
EMPHYSEMA HYPERTENSION												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. None												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 9-4-80, 19 to 9-19-, 1952, that (II) (we) last saw the deceased alive on 6-10-1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (II) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 9/20/82		
22b. SIGNATURE Degree Morgan										22d. ADDRESS 3125 MAIN STREET, MANCHESTER MD. 21102		
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL 23d. LOCATION CITY OR TOWN COUNTY STATE			
S.D. MORJARIA			Burial			9/21/82			Mt Pleasant Cemetery, Baltimore, Md.			
24. FUNERAL DIRECTOR NAME			ADDRESS						25a. DATE REG'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
Harry W. Haight, Sykesville, Md.									SEP 22 1982 John J. Cawieh			

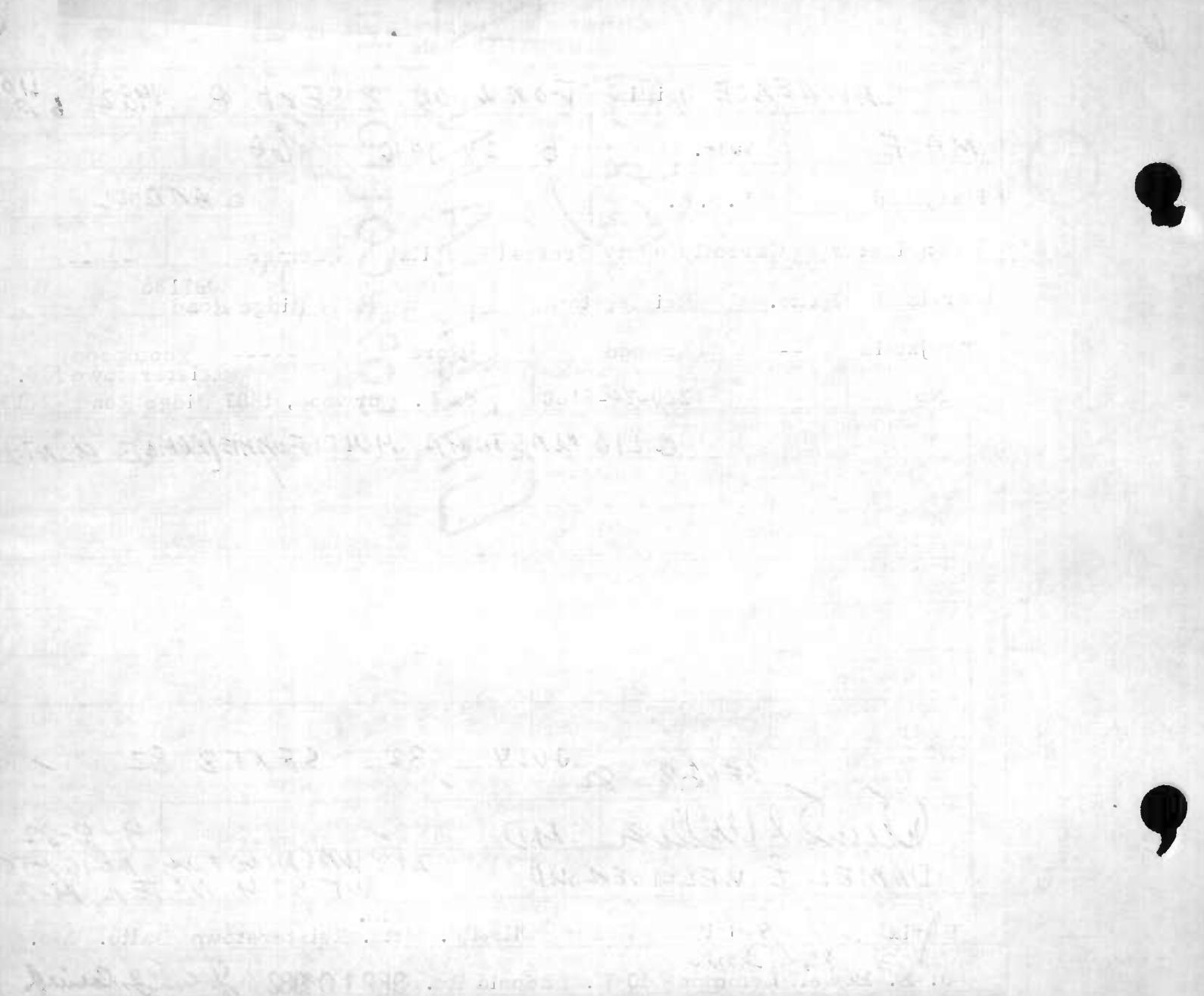


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be informed and a report made.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												82 23084	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
LAWRENCE Phillip Forwood						SEPT 8 1982			1940 6 PM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS			
MALE		Cauc.		6 24 1916			66			IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL			MD.			
Maryland		U. S. A.											
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer			12b. KIND OF BUSINESS OR INDUSTRY -----						
13a. STATE Maryland		13b. COUNTY Balto.		13c. CITY OR TOWN Reisterstown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 21136 1807 Ridge Road			
14. FATHER'S NAME FIRST Benjamin		MIDDLE ---		LAST Forwood			15. MOTHER'S MAIDEN NAME FIRST Cora			MIDDLE LAST Thompson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT Freda L. Forwood, 1807 Ridge Road 21136			ADDRESS Reisterstown Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GLIOBLASTOMA MULTIFORME (BRAIN) 3 MONTHS</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<p>1919 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any</p> <p>(b) _____ DUE TO, OR AS A CONSEQUENCE OF</p> <p>(c) _____ DUE TO, OR AS A CONSEQUENCE OF</p>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>SEPT 9 1982</u> to <u>SEPT 9 1982</u> , that (I) (we) last saw the deceased alive on <u>above</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (I) did (did not) view the body after death.												22c. DATE SIGNED 9-9-82	
22b. SIGNATURE <u>Daniel I. Lowell M.D.</u>			DEGREE M.D.			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL I. WELLIVER MD.			22e. ADDRESS 210 WASHINGTON HEIGHTS WESTMINSTER MD.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/11/1982			23c. NAME OF CEMETERY OR CREMATORIUM Cem. Grace Falls Rd. Meth. Reisterstown Balto. Md.			23d. LOCATION CITY OR TOWN COUNTY STATE				
24. FUNERAL DIRECTOR NAME J. E. Lowell Lemmon			ADDRESS 10 W. Padonia Rd.			25a. DATE REC'D. BY REGISTRAR SEP 10 1982			25b. REGISTRAR'S SIGNATURE <u>John J. Conroy</u>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 3 6 8 5		
										REG. NO.		
1. FOR STATE REGISTRAR			2a DATE OF DEATH							2b HOUR		
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	MONTH	DAY	YEAR	10			
Carroll B					Green	SEPT	10	1982	11 A.M.			
3. SEX			4 RACE	5. DATE OF BIRTH	6 AGE (IN YEARS LAST BIRTHDAY)					7b HOUR		
MALE			WHITE	MONT MAY 23 1892	90					10		
7a BIRTHPLACE COUNTRY			7b CITIZEN OF WHAT COUNTRY?	8	IF UNDER 1 YEAR					IF UNDER 24 HRS		
MD.			U.S.A.	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	MONTHS DAYS					MONTHS HOURS MIN.		
9. BALTIMORE CITY OR COUNTY OF DEATH			CARROLL							MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)	12b KIND OF BUSINESS OR INDUSTRY	
WESTMINSTER			WESTMINSTER NURSING CENTER							LABOR	FARM SUPPLY	
13a STATE MD.			13b COUNTY CARROLL	13c CITY OR TOWN WESTMINSTER	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		14a STREET ADDRESS			14b APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
							1437 Gorsuch Road					
14. FATHER'S NAME			FIRST Isaac	MIDDLE N.	LAST Green	15. MOTHER'S MAIDEN NAME						
						FIRST Fannie	MIDDLE	Flater			LAST	
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17. INFORMANT					ADDRESS	
NO			215-12-9017			RUTH LONG					1437 GORSUCH RD. 21157	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4292</u> <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.												
DUE TO, OR AS A CONSEQUENCE OF (b) _____												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>CARCINOMA OF BLADDER - PADGET'S DISEASE.</u>												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>8/14/74</u> to <u>9/10/82</u> , that (I) (we) lost sow the deceased alive on <u>9/10/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												
22b. SIGNATURE <u>Daniel I. Welliver</u>			DEGREE M.D.			ATTENDING PHYSICIAN			MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>9-10-82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>DANIEL I. WELLIVER</u>			22e. ADDRESS <u>218 WASHINGTON HEIGHTS</u>			23d. LOCATION CITY OR TOWN <u>WESTMINSTER</u>			COUNTY <u>CARROLL</u>	STATE <u>MD.</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>9-13-82</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>WESTMINSTER</u>			23d. DATE REC'D. BY BUREAU OF VITAL RECORDS REGISTRAR'S SIGNATURE <u>SEP 15 1982</u>			
24. FUNERAL DIRECTOR <u>PRITTS FUNERAL HOME WESTMINSTER MD.</u>												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										82 23686			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
<i>Joseph Marion Harris</i>						<i>Sept. 5, 1982</i>						8A M	
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
<i>Male</i>			<i>White</i>		<i>Jan. 11, 1889</i>		<i>93</i>			MONTHS	DAYS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8		9 B. BALTIMORE CITY OR COUNTY OF DEATH			YRS.			
<i>Md.</i>			<i>U.S.A.</i>		<i>MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></i>		<i>Carroll</i>			<i>Carroll</i>			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			MD.			
<i>Sykesville</i>			<i>7378 Springfield Ave</i>		<i>Store owner</i>		<i>Food</i>						
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			
<i>Md.</i>			<i>Carroll</i>		<i>Sykesville</i>		<i>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></i>			<i>7378 Springfield Ave.</i>			
14. FATHER'S NAME			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME								
<i>John</i>				<i>Harris</i>	<i>Bertha</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
<i>No</i>			<i>?</i>		<i>Jack Harris</i>		<i>Sykesville, Md.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 1. DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <i>4360 Cerebro-vascular accident</i>										<i>12 hrs</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Arteriosclerotic vascular disease ≥ 1 year</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>Sept 4, 1981</i> to <i>Sept 5, 1982</i> , that (I) (we) last saw the deceased alive on <i>Sept 4, 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>William A. Miller, M.D.</i>										22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>William A. Miller, M.D.</i>										22e. ADDRESS <i>118 Thomas Johnson Dr. Frederick, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <i>9-8-82</i>		23c. NAME OF CEMETERY OR CREMATORIAL <i>Springfield Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Sykesville Carroll Md.</i>					
24. FUNERAL DIRECTOR NAME <i>Harry W. Hight Sykesville, Md.</i>			ADDRESS		24e. DATE REC'D. BY REGISTRAR <i>SEP 9 1982</i>			24f. REGISTRAR'S SIGNATURE <i>John J. Conner</i>					

21 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 2 3 6 8 1
												REG. NO.
1. FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
10	Henry George Hendrickson						Sept. 7, 1982				3:50 P.M.	
	3. SEX	4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	IF UNDER 24 HRS		
	Male	White			Oct. 30, 1904			77	MONTHS	YEARS		
	7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co.			MD.		
	Ill.	U.S.A.										
	10. CITY OR TOWN OF DEATH Finksburg	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2020 Bollinger Mill Rd.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance			12b. KIND OF BUSINESS OR INDUSTRY Construction				
	13a. STATE Md.	13b. COUNTY Carroll	13c. CITY OR TOWN Finksburg	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 2020 Bollinger Mill Rd.					
	14. FATHER'S NAME Emil	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME Marguerite			FIRST	MIDDLE	LAST		
	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO. No			17. INFORMANT Hazel Hendrickson - Finksburg, Md.			ADDRESS				
	18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute respiratory failure, pulmonary 5150 DUE TO, OR AS A CONSEQUENCE OF (b) fibrosis, ASHD with cardiac failure, DUE TO, OR AS A CONSEQUENCE OF (c) cachexia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
	PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.											
	19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
	21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)							
	21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
	22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.	1-29 19 82			to 9-7- 19 82							
	22b. SIGNATURE Howard E. Hall, M.D., P.A.	MD			DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9-8-82			
	22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard E. Hall, M.D., P.A.				22e. ADDRESS PO Box 318 Sykesville, Md. 21784							
	23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 9-10-82			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Pleasant Cemetery			23d. LOCATION CITY OR TOWN Sykesville			COUNTY Carroll	
											STATE Md.	
	24. FUNERAL DIRECTOR NAME Harry W. Haight	ADDRESS Sykesville, Md.			25. SPEC. DATE FOR STAMP SEP 9 1982			25c. REGISTRAR'S SIGNATURE John J. Carroll				

task 1

the following questions and

answers the following questions

answers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certificate must be completed by one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 2 3 6 8 8				
												REG. NO.				
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
			JOHN V. A. HOONTZ						9 13 82						2100 M	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
MALE			WHITE			MONTH 1 DAY 5 YEAR 1895			87 YRS			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			CARROLL MD.				
MARYLAND			U. S. A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
WESTMINSTER			CARROLL COUNTY GENERAL HOSPITAL			CARPENTER										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
MARYLAND			CARROLL			WESTMINSTER						925 PLEASANT VALLEY RD.				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME													
JEREMIAH			FLORA													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO			187-16-6972			RALPH HOONTZ			925 PLEASANT VALLEY RD.			WEEKS				
WESTMINSTER			WESTMINSTER 21157													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1991</u> RESPIRATORY INSUFFICIENCY																
DUE TO, OR AS A CONSEQUENCE OF (b) <u>MALIGNANT MESOTHELIOMA</u>																
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			21g. CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>9/13/1982</u> to <u>9/13/1982</u> , that (I) (we) last saw the deceased alive on <u>9/13/1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <u>Robert J. Croom Jr. MD</u>			22c. DEGREE			22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS			22f. DATE SIGNED 9/13/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>			23b. DATE <u>9/17/82</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>EVERGREEN MEMORIAL GARDENS</u>			23d. LOCATION CITY OR TOWN <u>FINNSBURG</u> COUNTY <u>CHARLES</u> STATE <u>M.D.</u>							
24. FUNERAL DIRECTOR NAME <u>Fletcher</u>			ADDRESS <u>254 E. Main St.</u>			25a. DATE REC'D. BY DIRECTOR <u>SEP 17 1982</u>			25b. DIRECTOR'S SIGNATURE							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it may be given to the funeral director. page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be held within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	2	2	3	6	8	9
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR							
George William Korman						9 23 82			1324 P M							
3. SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			82 yrs.		MONTHS DAYS		HOURS MIN.					
10 CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County Gen. Hospital							12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter Supt.			12b. KIND OF BUSINESS OR INDUSTRY Construction			
13a. STATE Md.			13b. COUNTY Balto.		13c. CITY OR TOWN Reisterstown			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 307 Cherry Hill Road						
14 FATHER'S NAME FIRST MIDDLE LAST Frederick William Korman			15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Louise France													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-14-8773			17. INFORMANT Margaret Noel			ADDRESS 2515 Cornstalk Drive Finksburg, Md. 21048							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4100										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
myocardial infarction (acute) (b) atherosclerotic heart disease (c)																
DUE TO, OR AS A CONSEQUENCE OF																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.) 9/19			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (1) (this hospital) attended the deceased from saw the deceased alive on 9/23 1982 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.										19 82 to 9/23 82, that (1) (we) last						
22b. SIGNATURE Park W. Espenshade Jr.										22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Park W. Espenshade Jr.										22e. ADDRESS Carroll Co. Gen. Hospital, Westminster, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 27, 1982			23c. NAME OF CEMETERY OR CREMATORIAL All Saints Cemetery			23d. LOCATION CITY OR TOWN Reisterstown, Balto., Md.							
24. FUNERAL DIRECTOR NAME H. Eichholtz									25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE SEP 28 1982 John J. Gobert							



X  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director (Pages 1 and 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 301 W. Preston Street, Baltimore, Maryland 21201.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 2 3 6 9 0			
												REG. NO.			
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			9/26/82		12 p m	
Wallace William Krout															
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE			White			MONTH / DAY YEAR			52			MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8.			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
Maryland			USA			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Carroll Co.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Sykesville			Springfield State Hospital			UNEMPLOYED									
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
MD. ET			Baltimore			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			2639 Hampden Ave.						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME												
Wallace			FIRST Krout SP. MIDDLE			Alice									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			White			
YES Army			1951-53			FAYE Krout			2639 Hampden Ave. Baltimore, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4920 IMMEDIATE CAUSE (a) <i>Severe cardiovascular failure. Rx of MI.</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Severe pulmonary embolism</i>															
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Chronic obstructive pulmonary disease</i>															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED									20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (we) attended the deceased from 9/26/82, 19 82, to 9/26/82, 19 82, that (I) (we) lost saw the deceased alive on 9/26/82, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>Barbara</i>			22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>									22d. DATE SIGNED 9/26/82			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) STRATHIL D. KARRELL MD.			22e. ADDRESS Springfield Hosp. Center, Sykesville												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/30/82			23c. NAME OF CEMETERY OR CREMATORIAL Crest Lawn			23d. LOCATION CITY OR TOWN Carroll Co., Md. COUNTY STATE						
24. FUNERAL DIRECTOR NAME Paul E. Chenoweth 3rd.			ADDRESS 3617 Chestnut Ave.			25a. DATE REC'D. BY REGISTRAR SEP 30 1982			25b. REGISTRAR'S SIGNATURE John J. Church						

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147

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or given

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2	2 3 6 9 1
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST <u>JOHN</u>	MIDDLE <u>Joseph</u>	LAST <u>MAGEE</u>	2a. DATE OF DEATH			MONTH 9	DAY 22	YEAR 82	2b. HOUR 14 25 P.M.	
3. SEX <u>Male</u>			4. RACE <u>White</u>			5. DATE OF BIRTH MONTH <u>April</u>			DAY <u>9</u>	YEAR <u>1903</u>	6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Md.</u>			7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>CARROLL</u>				
10. CITY OR TOWN OF DEATH <u>Westminster</u>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <u>CARROLL Co. Hospital</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Nursing Aide</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Hospital</u>				
13a. STATE <u>Md.</u>			13b. COUNTY <u>CARROLL</u>			13c. CITY OR TOWN <u>Woodbine</u>			13e. STREET ADDRESS <u>1433 Hounds Mill Rd.</u>				
14. FATHER'S NAME FIRST <u>UNK</u>			15. MOTHER'S MAIDEN NAME FIRST <u>UNK</u>										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <u>No</u>			16b. SOCIAL SECURITY NO. <u>24 36 1752</u>			17. INFORMANT ADDRESS <u>Viegic Magee Woodbine, Md.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>1539</u>			DUE TO, OR AS A CONSEQUENCE OF (b) <u>COPD, ASTH and Renal Insufficiency</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 Days</u>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost.			DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>CLOSURE, COLOSTOMY, AFTER RESECTION FOR CANCER</u>													
19a. DATE OF OPERATION <u>9-17-82</u>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>COLOSTOMY</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the physician) attended the deceased from <u>9-14-82</u> to <u>9-22-82</u> , that (I) (we) lost saw the deceased alive on <u>9-22-82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>R. J. H. M.</u>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>9-22-82</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>ROBERT J. H. M.</u>			22e. ADDRESS <u>WESTMINSTER, MD - 418 F MALCOLM DR.</u>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>9-25-82</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>Morgan Chapel Cemetery</u>			23d. LOCATION CITY OR TOWN <u>Woodbine</u>			STAFF	
24. FUNERAL DIRECTOR NAME <u>Harry W. Haight</u>			25a. DATE REC'D. BY REGISTRAR <u>SEP 24 1982</u>			25b. REGISTRAR'S SIGNATURE <u>John J. Canfield</u>							

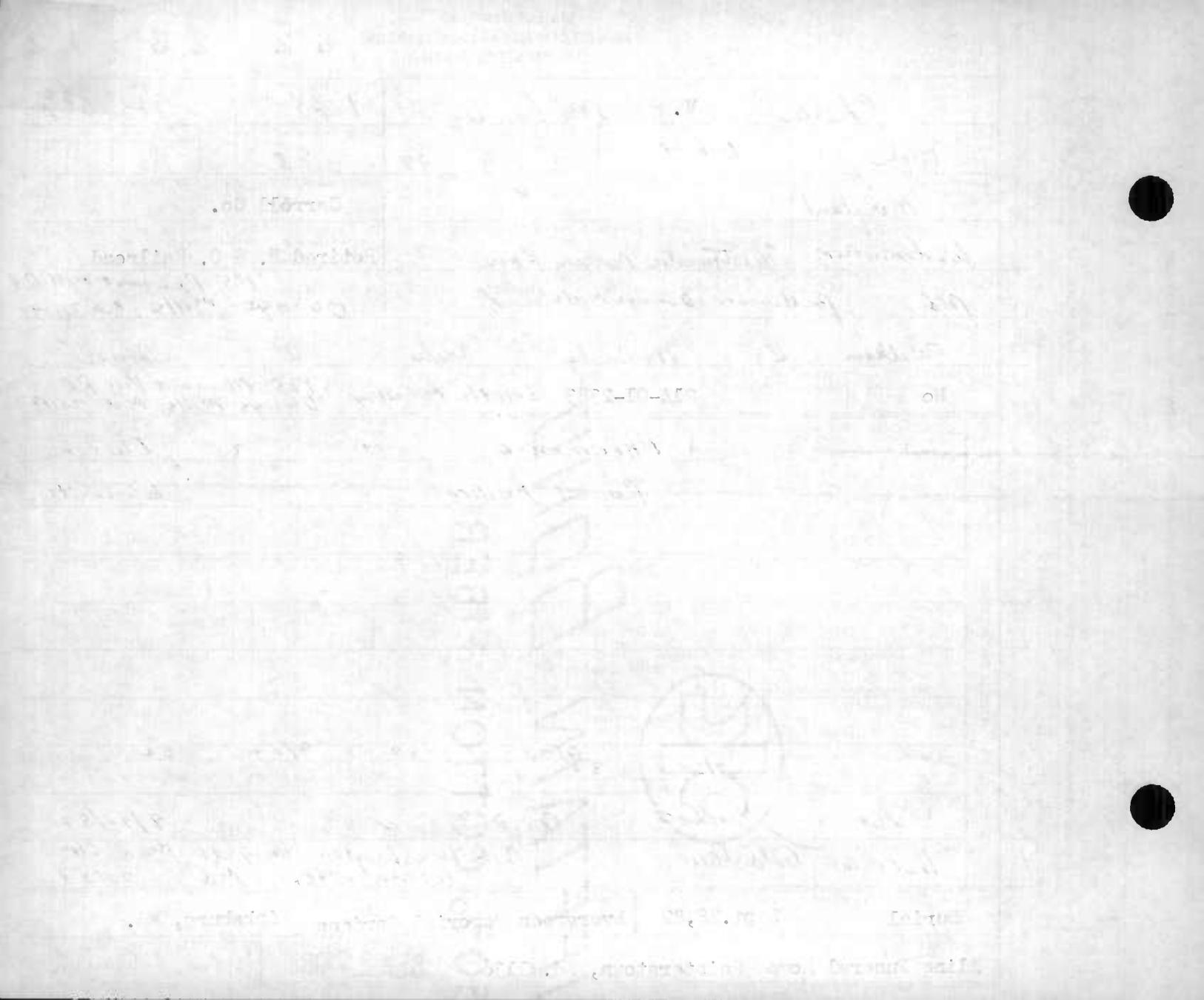


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical certifying physician must be notified of the same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2	2 3 6 9 2	
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Charles			V.		Mc Cauley	9-24-		82	82	6 20 P M		
3. SEX			4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Male			White	MONTH	DAY	YEAR	83			MONTHS	YEARS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland			US						Carroll Co.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Westminster			Westminster Nursing Home			Retired B. & O. Railroad						
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Md.			Baltimore	Owings Mills				125 Pleasant Hill Rd Owings Mills, Md 21117				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME						
William			C.		Mc Cauley	Adele						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
No			214-01-2383			Loretta Mc Cauley			125 Pleasant Hill Rd Owings Mills, Md 21117			
18. CAUSE OF DEATH: (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c)												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Two week</u>												
6 months												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>9/24</u> , 19 <u>82</u> , to <u>9/24</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>9/24</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Norman Goldstein</u>			DEGREE M.D.			ATTENDING PHYSICIAN	<input checked="" type="checkbox"/> DIRECTOR	<input type="checkbox"/> STAFF PHYSICIAN	22c. DATE SIGNED <u>9/28/82</u>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS <u>218 Washington Heights Med Ctr Westminster, Md 21157</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 28, 82			23c. NAME OF CEMETERY OR CREMATORIAL Evergreen Memorial Gardens			23d. LOCATION CITY OR TOWN Finksburg, Md. COUNTY STATE			
24. FUNERAL DIRECTOR NAME Eline Funeral Home			ADDRESS Reisterstown, Md. 21136			25a. DATE REC'D. BY REGISTRAR <u>SEP 27 1982</u>			25b. REGISTRAR'S SIGNATURE <u>John J. Cahill</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2	2 3 6 9 3																
												REG. NO.																	
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH			DAY			YEAR			2b. HOUR		
			Edward George Mergehenn												9-30-82			8 2			2 3 6 9 3			6 15 AM					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS														
MALE			CAUCASION			MONTH DAY YR			85			MONTHS DAYS			HOURS MIN.														
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH																				
Maryland			U.S.A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Carroll County MD.																				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY																				
Sykesville			Sykesville Elder Care			Butcher			Market																				
13. STATE			13a. COUNTY			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS																				
Md.			Howard			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2618 Liter Court 21043																				
4. FATHER'S NAME			5. MOTHER'S NAME			6. ADDRESS			7. INFORMANT			8. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
John			Mergehenn			Ellicott City, Md. 21043			William H. Mergehenn, 2618 Liter Court																				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. IMMEDIATE CAUSE (a)			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																				
YES			319-26-3672A			Coronary thrombosis			PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)																				
4100									DUE TO, OR AS A CONSEQUENCE OF (b)																				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						DUE TO, OR AS A CONSEQUENCE OF (c)			A.S.C.V.D.																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																				
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>																				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE														
22a. I certify that (I) (this hospital) attended the deceased from <u>February 2, 1982</u> to <u>September 30, 1982</u> , that (I) (we) last saw the deceased alive on <u>August 20, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																													
22b. SIGNATURE Joseph DeGalan			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9-30-82																				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph L. Chapelle			22e. ADDRESS 6342 Barnett Ave. Sykesville, Md.																										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 10/2/82			23c. NAME OF CEMETERY OR CREMATORIAL Loudon Park Cemetery			23d. LOCATION CITY OR TOWN Baltimore			COUNTY Maryland			STATE														
24. FUNERAL DIRECTOR NAME Witzke Catonsville Funeral Home, P.A. 21228			ADDRESS			25a. DATE REC'D. BY REGISTRAR OCT 1 - 1982			25b. REGISTRAR'S SIGNATURE John G. Canfield																				

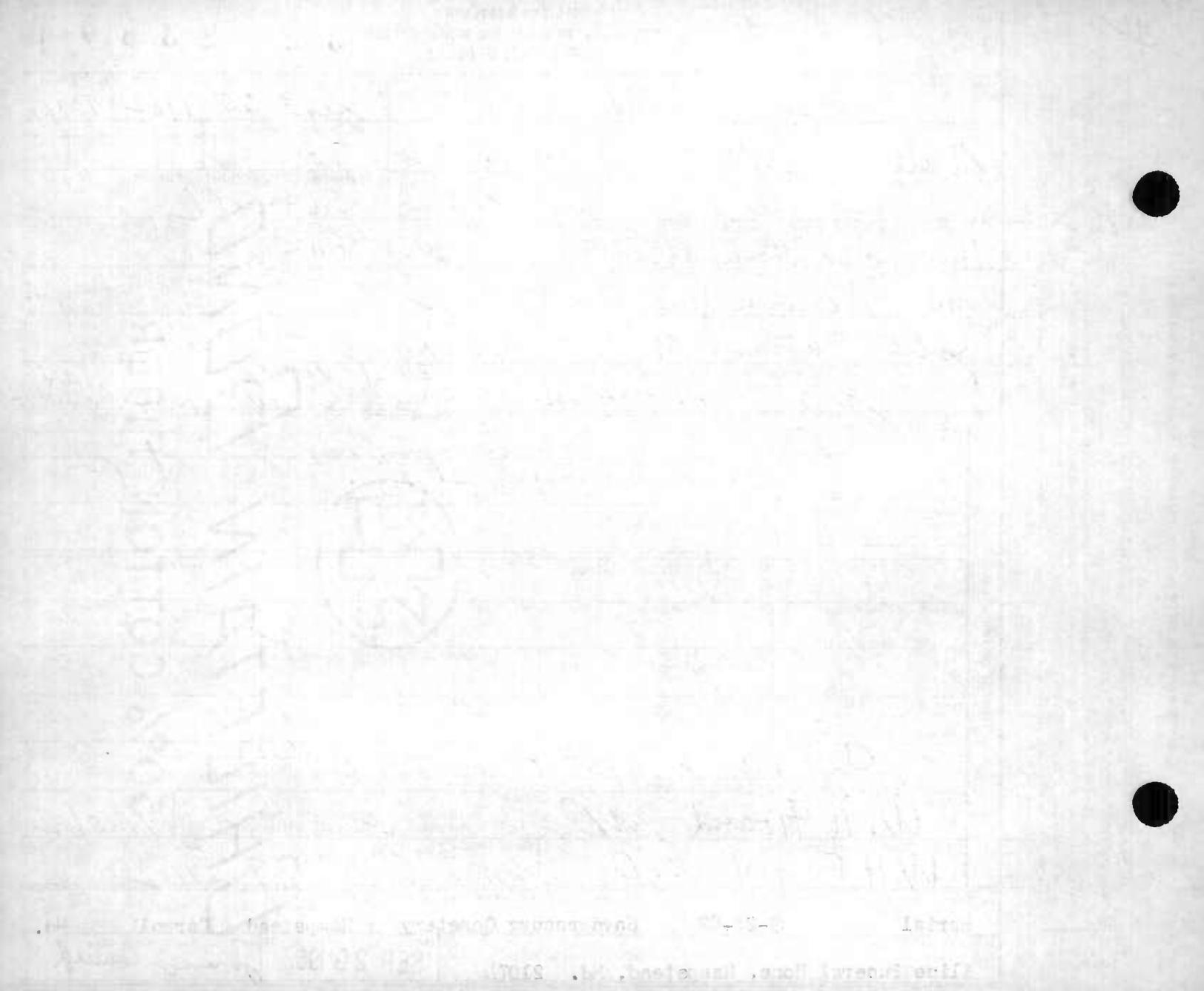


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use in the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled in within 2 hours after death and with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 3 6 9 4					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Jesse Edward Miller						Sept 25 1982						730 PM			
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male			White		Oct 16 - 1903		78			MONTHS	YEARS	MONTHS	HOURS		
7b. BIRTH PLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Carroll Co			USA				Carroll			Farmer			MD.		
11. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			2332 Synderbury Rd.					
Hampstead			Home 2332 Synderbury Rd.		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		2332								
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		15. MOTHER'S MAIDEN NAME			MAY			SWITZER		
Md			Carroll		Hampstead		16. SOCIAL SECURITY NO.			213-14-2622			ADDRESS		
16a. HAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. IMMEDIATE CAUSE (a)		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			2332 Synderbury Rd.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO			1619		Elmer Miller		DUE TO, OR AS A CONSEQUENCE OF (b) <i>Carcinoma Larynx</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						1 yr.		
			16c. DUE TO, OR AS A CONSEQUENCE OF (c) <i>with metastasis</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) this hospital attended the deceased from <i>Aug 19, 1966</i> to <i>Sept 25, 1982</i> , that (I) (we) lost saw the deceased alive on <i>Feb. 18, 1982</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>W. H. Foard MD</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>9/25/82</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>W H Foard MD</i>			22e. ADDRESS 3223 Main St Marlboro Rd 21107												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-28-82		23c. NAME OF CEMETERY OR CREMATORIAL Snyderbury Cemetery		23d. LOCATION CITY OR TOWN Hampstead COUNTY Carroll STATE Md.								
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md. 21074			ADDRESS			25a. DATE REC'D. BY REGISTRAR SEP 29 1982			25b. REGISTRAR'S SIGNATURE <i>John J. Conwell</i>						



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PAGE 3. RETAIN PAGE 5 FOR YOUR RECORDS.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

1- STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH8 2 2 3 6 9 5  
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR	
Russell			William	Monroe		<input checked="" type="checkbox"/>	9	1	1982	M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST <u>52</u> YRS.	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
Male	White	June 2, 1930	MONTHS DAYS	HOURS	MIN	<input type="checkbox"/>	9	1	1982	M	
7a. BIRTHPLACE (STATE OR FEDERAL TERRITORY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH	10d. HOUR					
Virginia	USA	<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Carroll County, MD.	3:12A M					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR WORK OR WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Westminster			Carroll County General Hospital			Labor			Carnival		
13a. STATE Md. 21771			13b. COUNTY Carroll		13c. CITY OR TOWN Mt. Airy	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 4040 Twin Arch Rd.				
14. FATHER'S NAME FIRST Sidney			MIDDLE Monroe	LAST Sr.	15. MOTHER'S MAIDEN NAME FIRST Viola			MIDDLE Pearl	LAST Bryant		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. 577-42-5754			17. INFORMANT Elizabeth Perkins			ADDRESS Same as #13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:  IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF  4280 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.  (b) DUE TO, OR AS A CONSEQUENCE OF  (c)											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE
22a. I certify that I took charge of the remains described above, held an <input type="checkbox"/> Autopsy, <input checked="" type="checkbox"/> Inspection, <input type="checkbox"/> Inquiry, and in my opinion death resulted from <input type="checkbox"/> Natural causes, <input type="checkbox"/> Accident, <input type="checkbox"/> Suicide, <input type="checkbox"/> Homicide, <input type="checkbox"/> Undetermined manner.											
ACTUAL SIGNATURE <i>Howard D. Smith</i>											TITLE (SPECIFY) M.D. Deputy Chief MEDICAL EXAMINER
EXAMINER'S NAME (TYPE OR PRINT)			Thomas D. Smith, M.D.			ADDRESS			DATE SIGNED <u>9/2/82</u>		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Sept. 4, 1982			23c. NAME OF CEMETERY OR CREMATORIAL Laytonsville			23d. LOCATION CITY OR TOWN Laytonsville		
24. FUNERAL DIRECTOR NAME FRANCIS H. BARBER			ADDRESS TAYTONSVILLE, MD. 20872			25a. DATE REC'D. BY REGISTRAR SEP 7 1982			25b. REGISTRAR'S SIGNATURE <i>Jan. 9. 1982</i>		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

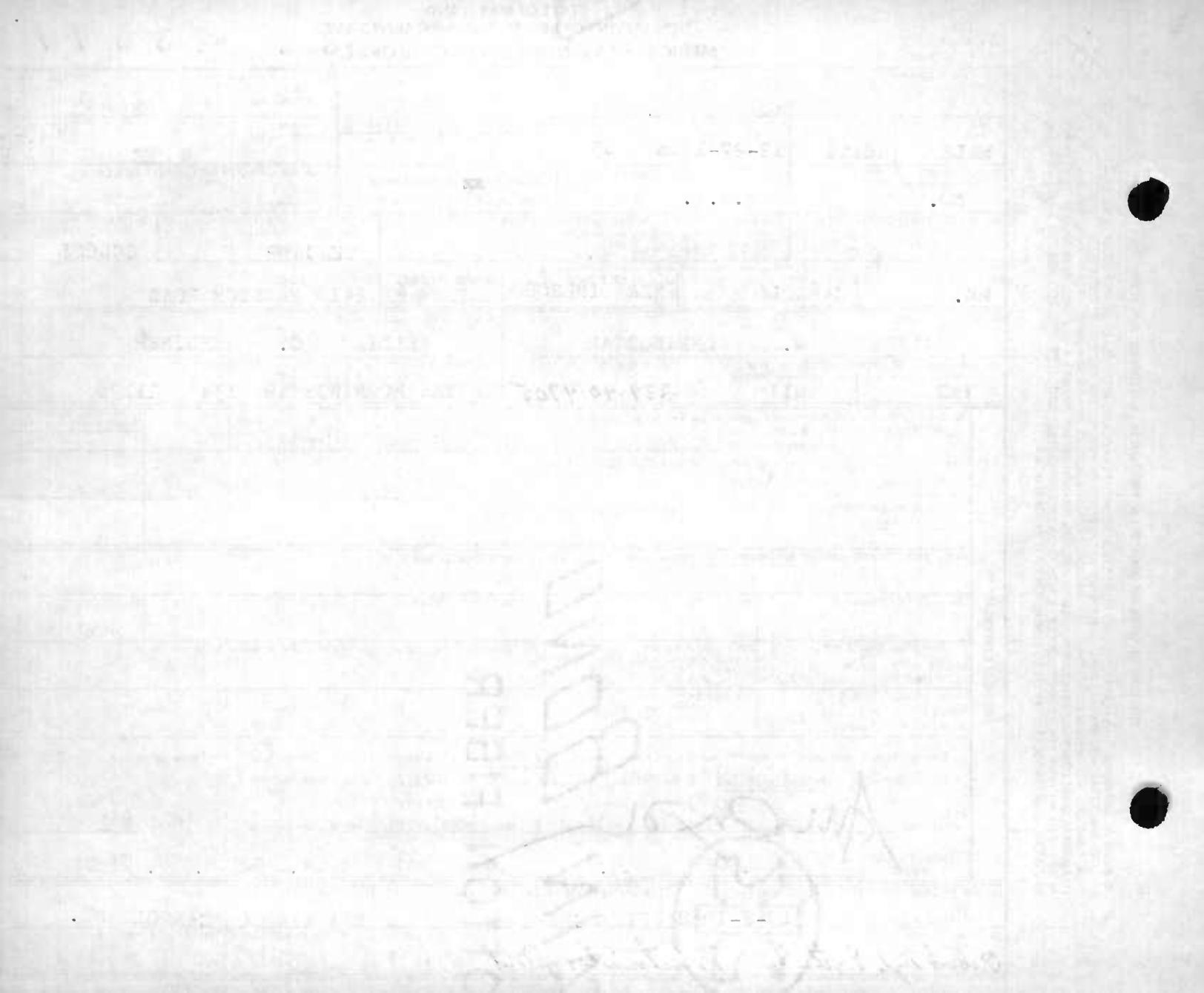
## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8 2 2 3 6 9 6		
1- STATE REGISTRAR			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> MONTH 9-20-82 DAY YEAR									2b. HOUR		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2c. DATE PRONOUNCED DEAD 9-20-82			2d. HOUR 2:14 PM					
MILES M. MORELAND														
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN.					
Male	White	July 3, 1914	68 yrs.	2	17									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/>		DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.			
Penns.		U.S.A.												
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md. 21048			13b. COUNTY Carroll		13c. CITY OR TOWN Finksburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 3426 Murray Rd.					
14. FATHER'S NAME James			MIDDLE Milton		LAST Moreland		15. MOTHER'S MAIDEN NAME Manerva			Jane				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) No 188-12-3498A			17. INFORMANT Ruth V. Moreland, Same As #13			ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) Arteriosclerotic cardiovascular disease 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (o) starting the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o):														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Margie Korell</i>												TITLE (SPECIFY) Assistant MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.												DATE 9-21-82 SIGNED		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-24-1982			23c. NAME OF CEMETERY OR CREMATORIAL Evergreen Memorial			23d. LOCATION CITY OR TOWN Finksburg, Carroll, Md.			COUNTY	STATE	
24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md.												25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 23 1982 <i>John J. Coughlin</i>		
BP														
DHMH - 17 (VR A15 ME (5))														
20M 4/82														



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM 1 PM. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2 3 6 9 7				
1- STATE REGISTRAR		1 DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				20. DATE KNOWN <input checked="" type="checkbox"/> MONTH DAY YEAR				2b HOUR		
		MARSHALL A. MORN INGSTAR								9 28 1982 M						
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) YRS.		IF UNDER 1 YR.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c DATE PRONOUNCED DEAD MONTH DAY YEAR				2d HOUR
MALE		WHITE		12-27-1916		65						9 28 1982 11:30 p.m.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?				8.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
MD.		U.S.A.										Carroll County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY						
New Windsor		2418 Marston Rd.				TEACHER				SCHOOL						
13a. STATE MD.		13b. COUNTY CARROLL		13c. CITY OR TOWN NEW WINDSOR		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2418 MARSTON ROAD								
14. FATHER'S NAME FIRST MIDDLE LAST		CLYDE W. MORNINGSTAR				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				NELLINE O. SHRINER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS						
YES		WWII				234-40-4705				MARTHA MORNINGSTAR				13e	21176	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic obstructive pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF 4960 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?						
										YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE						
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Ann M. Dixon, M.D.</u>												TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				
EXAMINER'S NAME (TYPE OR PRINT)												DATE SIGNED 9-29-82				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 10-2-1982		23c. NAME OF CEMETERY OR CREMATORIAL PIPE CREEK				23d. LOCATION CITY OR TOWN NEW WINDSOR CARROLL MD.				COUNTY STATE				
BURIAL																
24. FUNERAL DIRECTOR NAME		ADDRESS				25a. DATE REC'D. BY REGISTRAR OCT 4 1982				25b. REGISTRAR'S SIGNATURE <u>John J. Curran</u>						
Robert Kyle Bratton Sr.		Westminster, Md.														
BP																
DHMH - 17 (VR A15 ME (5)) 20M 4/B2																



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as having any injury, or other traumatic event, then medical examiner should be notified of death.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	2	3	6	9	8
												REG. NO. 9 16 82						
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR						
1. DECEASED NAME (TYPE OR PRINT)			FIRST John			MIDDLE Martin			LAST Neeson			9 16 82			7:00P M			
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH 6 DAY 1 YEAR 01			6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS			IF UNDER 1 YEAR MONTHS 0 DAYS			IF UNDER 24 HRS HOURS 0 MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.									
10. CITY OR TOWN OF DEATH Sykesville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Springfield Hospital Center			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) dishwasher			12b. KIND OF BUSINESS OR INDUSTRY none									
13a. STATE Maryland			13b. COUNTY Hartford			13c. CITY OR TOWN Belair			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 19 Baltimore Pike						
14. FATHER'S NAME FIRST OAK			15. MOTHER'S MAIDEN NAME MIDDLE UNK LAST															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-30-8353			17. INFORMANT ADDRESS SHC Ward Chart												
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1750												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if lost (b)																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
DUE TO, OR AS A CONSEQUENCE OF (b)																		
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) none																		
19a. DATE OF OPERATION 1976			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED breast Ca			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) this hospital attended the deceased from 7-27, 19 70, to 9-16, 19 82, that (I) (we) last saw the deceased alive on 9-16, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																		
22b. SIGNATURE Robert J. Guziec, MD			22c. DEGREE															
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert J. Guziec, MD			22e. ADDRESS SHC Sykesville, Md. 21784															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-20-82			23c. NAME OF CEMETERY OR CREMATORIAL Springfield Cemetery			23d. LOCATION CITY OR TOWN Sykesville COUNTY Carroll Md.									
24. FUNERAL DIRECTOR NAME Harry W. Haight ADDRESS Sykesville, Md.						25a. DATE REC'D. BY REGISTRAR SEP 20 1982			25b. FURNISHES SIGHTING John & Conie									

Serial book 102.1-38910

Armen - English dictionary

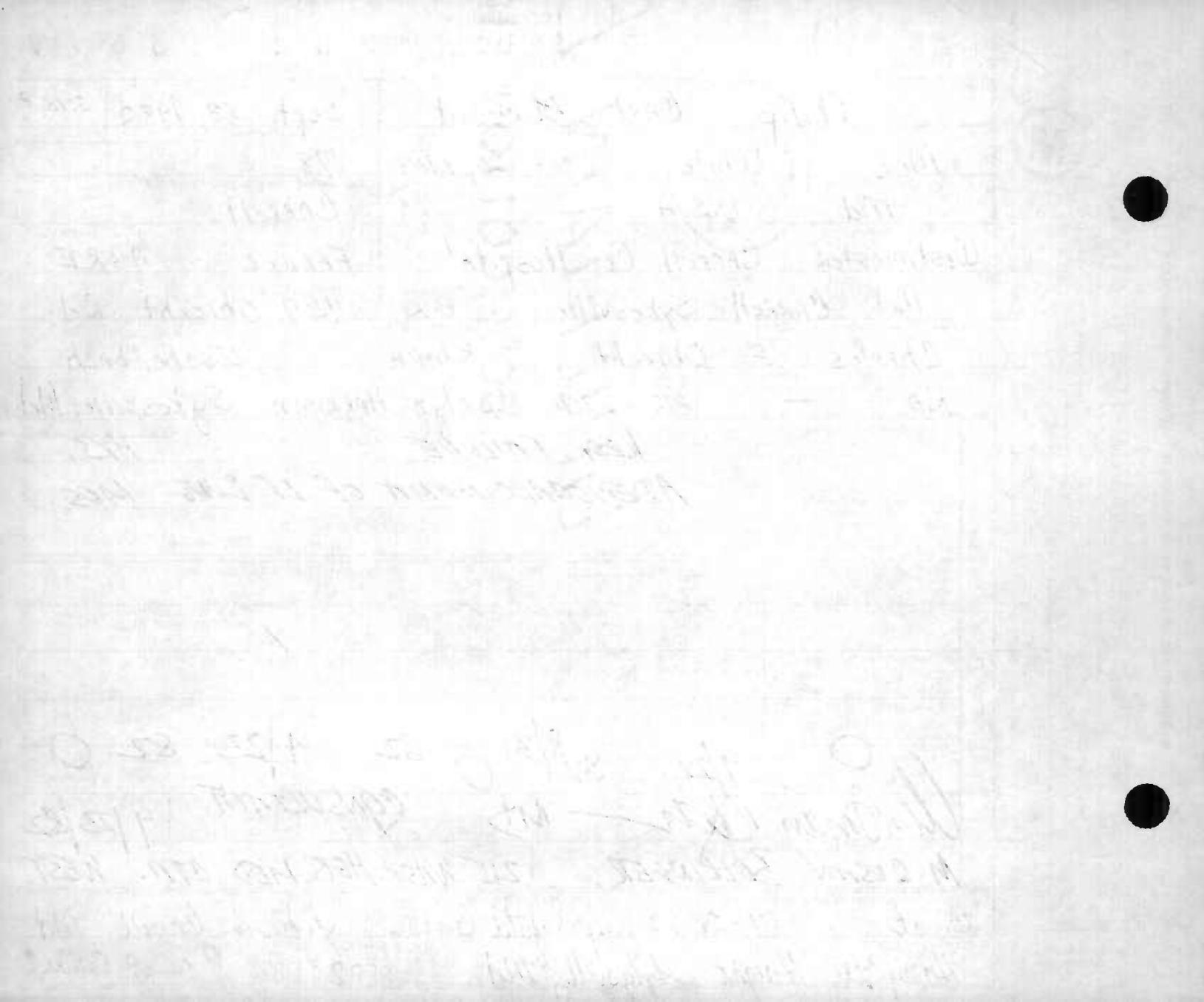
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2	2 3	6 9	9									
										REG. NO.												
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE		LAST			2a DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR				
		Philip			CARL			Obrecht					Sept. 23, 1982					3:15 P.M.				
3. SEX		Male			RACE			White		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS					
										MONTH Oct. 20, 1903			YEAR		MONTHS		DAYS		HOURS			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		Md.			7b. CITIZEN OF WHAT COUNTRY?			U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		9. BALTIMORE CITY OR COUNTY OF DEATH							
															Carroll							
10. CITY OR TOWN OF DEATH		Westminster			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			CARROLL Co. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			FARMER				12b. KIND OF BUSINESS OR INDUSTRY					
															AGRI.							
13a. STATE		Md.			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		437 Obrecht Rd.								
					Carroll		Sykesville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
14. FATHER'S NAME		Charles			F. Obrecht			15. MOTHER'S MAIDEN NAME			Klara				Eschenbach							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		No			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				APPROXIMATE AGE/PERIOD BETWEEN ONSET AND DEATH							
					212 20 9170			17. INFORMANT			Carlyn Harrison				Sykesville Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY:					IMMEDIATE CAUSE (a)			RESP. FAILURE							MRS.							
		1629																				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first					(b)			DUE TO, OR AS A CONSEQUENCE OF ADENOCARCINOMA OF LT. LUNG														
					(c)			DUE TO, OR AS A CONSEQUENCE OF														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)																	
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (1) this hospital attended to deceased from _____ to _____, 19_____, to _____, 19_____, and that (2) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) did (did not) view the body after death.		22b. DATE			22c. ATTENDING PHYSICIAN			22d. MEDICAL DIRECTOR			22e. STAFF PHYSICIAN			22f. DATE SIGNED								
		8/31/82			CONSULTANT									9/23/82								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		H. SUSAN BOTTINGER			22e. ADDRESS			22f. ADDRESS			22g. ADDRESS				22h. ADDRESS							
					215 WASH. HGS. MED. CTR. WEST.																	
23a. BURIAL, CREMATION, REMOVAL (CITY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE								
Burial		9-26-82			Springfield Cemetery			Springfield			Carroll			Md.								
24. FUNERAL DIRECTOR NAME		ADDRESS						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Harry W. Haight		Sykesville, Md.						SEP 24 1982			John J. Carroll											



TO HOSPITAL OR ATTENDING PHYSICIAN- The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 23 / 00		
1 - FOR STATE REGISTRAR											REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR	2b. 264005 P. 9-30-82 1605 M	
Sylvan						Pleet						8 2 23 / 00		
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 12 01 16			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS 65 YRS.			7. IF UNDER 24 HRS MONTHS HOURS MIN. 1605 M		
7a. BIRTHPLACE COUNTRY MARYLAND			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL COUNTY			MD.		
10. CITY OR TOWN OF DEATH WESTMINSTER			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MAIN ST.			12a. USUAL OCCUPATION (TYPE OF WORK OR MODE OF WORKING LIFE) MERCHANT			12b. KIND OF BUSINESS OR INDUSTRY RETAIL			APT. B-2 #21157		
13a. STATE MARYLAND			13b. COUNTY CARROLL			13c. CITY OR TOWN WESTMINSTER			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 418 BALDWIN DR.		
14. FATHER'S NAME FIRST EMANUEL			MIDDLE E.			LAST PLEET			15. MOTHER'S MAIDEN NAME FIRST FANNIE			MIDDLE MANKO		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR RECORDS) WWII-ARMY			16c. SOCIAL SECURITY NO. 202-09-0775			17. INFORMANT JEFFREY PLEET			ADDRESS 1210 RAMBLEWOOD RD. BALTO., MD 21239		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4100</u> <u>Acute Myocardial Infarction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic Heart Disease</u> (c) <u></u>													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8-9-81	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>8-9-81</u> to <u>9-30-81</u> , that (I) (we) last saw the deceased alive on <u>8-9-1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.														
22b. SIGNATURE <u>Chitrachedu Naganna MD</u>			22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9/30/81								
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CHITRACHEDU NAGANNA</u>			22f. ADDRESS <u>1745 Main Street Westminster MD 21157</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE OCT. 4, 1982			23c. NAME OF CEMETERY OR CREMATORIAL HAR SINAI			23d. LOCATION CITY OR TOWN BALTIMORE			COUNTY STATE MARYLAND		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.			25a. DATE REC'D. BY REGISTRAR ADDRESS 6101 REISTERSTOWN RD. BALTO., MD 21215			25b. REGISTRAR'S SIGNATURE John J. Carroll								



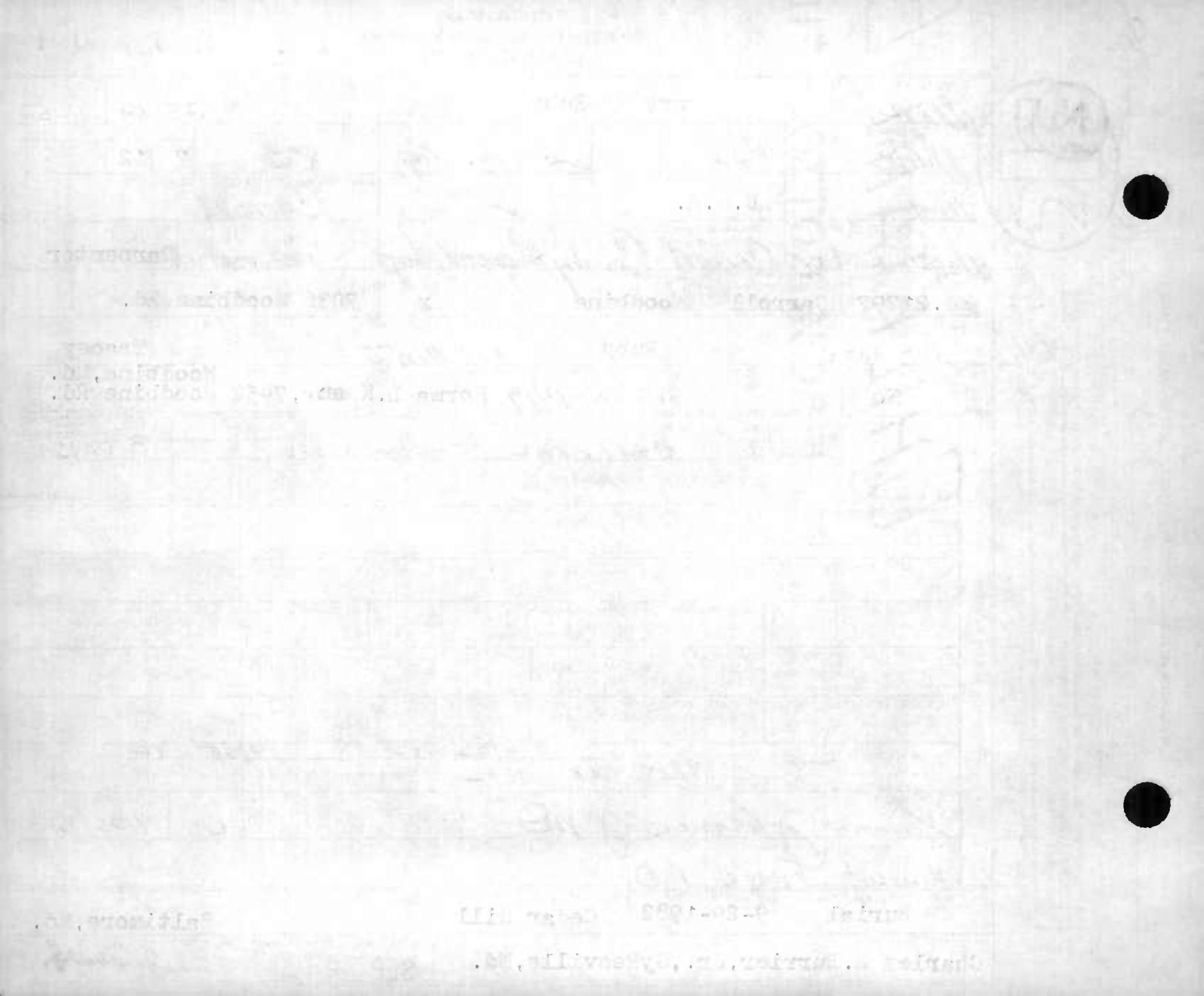
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Report must be refiled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Page 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 3 7 0 1								
										REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
Walker				Henry	Ruby	9 25 82			0105 M									
3. SEX			4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male			Ca.		8 13 89			83			YRS. 7	MONTHS 12	DAYS 12	HOURS 00	MIN. 00			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Md.			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Carroll			Retired. Carpenter						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			12b. STREET ADDRESS			12b. KIND OF BUSINESS OR INDUSTRY						
Westminster			Carroll County General Hosp.			NO			7036 Woodbine Rd.			Carpenter						
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. ADDRESS					
Md. 21797			Carroll		Woodbine		Charles			Georgeanna			Woodbine, Md.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
No			21072-1479			Norma L. Keen, 7452 Woodbine Rd.			CEREBRAL THROMBOSIS			3 DAYS						
18b. CONDITIONS, IF ANY, WHICH GOVE RISE TO IMMEDIATE CAUSE (b), STATING THE UNDERLYING CAUSE, IF ANY.			18c. DUE TO, OR AS A CONSEQUENCE OF (b)			18d. DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/22 1982 to 9/25 1982, that (I) (we) last saw the deceased alive on 9/25 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE Vincent J. Fiocco, M.D.			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 9/25/82									
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Vincent J. Fiocco, M.D.			22f. ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9-29-1982			23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill			23d. LOCATION CITY OR TOWN			23e. COUNTY Baltimore, Md.						
24. FUNERAL DIRECTOR Charles W. Burrier, Jr., Sykesville, Md.			25a. DATE REC'D. BY REGISTRAR SEP 29 1982			25b. REGISTRAR'S SIGNATURE John J. Cawley												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove from paper. Pages 1 and 2 should be filed within 72 hours and retained with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be informed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										82 23702							
										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
CARROLL E. SAUMENIG						Sept. 21, 1982						3:45 A.M.					
1c. SEX			4c. RACE			5c. DATE OF BIRTH			6c. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male			White			MONTH Aug. 18, 1903 DAY YEAR			79 YRS			MONTHS		DAYS			
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9c. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Balto. Md.			USA						Carroll								
10c. CITY OR TOWN OF DEATH			11c. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12c. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Westminster			Westminster Nursing & Convalescent			Retired Postal Clerk											
13c. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS								
Md.			Balto.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			99 Berrymans Lane								
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME														
FIRST Howard			MIDDLE E.			LAST Saumenig			FIRST Rose			MIDDLE Lee		LAST Oursler			
16c. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17c. INFORMANT			ADDRESS								
No			219-42-1198			Miss. Edna M. Uhler			Reisterstown, Md.								
18c. CAUSE OF DEATH (Enter only one cause per line for item 1b, 1c, and 1d.) PART 1. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
IMMEDIATE CAUSE (a) 4360										Central Vascular Accident 2 years							
DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																	
DUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>July 10</u> , 1979, to <u>Sept. 21</u> , 1982, that (I) (we) last saw the deceased alive on <u>Sept. 20</u> , 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE C.E. McWilliams										DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9-21-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 4904 Reisterstown Rd. Reisterstown, Md. 21136														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Sept. 23, 82			23c. NAME OF CEMETERY OR CREMATORIAL Druid Ridge Cemetery			23d. LOCATION CITY OR TOWN Pikesville, Md.			COUNTY		STATE			
Burial																	
24. FUNERAL DIRECTOR NAME Eline Funeral Home										ADDRESS Reisterstown, Md. 21136			25a. DATE REC'D. BY REGISTRAR SEP 24 1982			25b. REGISTRAR'S SIGNATURE John J. Cahill	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 3 7 0 3	
										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
Belle Eugenia Saylor						Sept. 28, 1982			1840 M		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female		White		June 8 1903			79				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH	
Carroll County		U.S.A.					Carroll			Westminster	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Carroll County General Hospital										12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Maryland		Carroll		Westminster		13e. STREET ADDRESS					
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Grove		Martha		No		219-20-2561		Mrs. Nancy S. Strine 523 Blizzard Lane Westminster, Md. 21157			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4340 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arterial atherosclerosis</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>atherosclerotic heart disease - arteriosclerosis</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>July 23, 1982</u> , to <u>Sept. 28, 1982</u> , that (I) (we) last saw the deceased alive on <u>Sept. 28, 1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED <u>9/27/82</u>	
22b. SIGNATURE <u>John S. Harshley, MD</u>		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>JOHN S HARSHLEY, MD</u>		22e. ADDRESS <u>8 anchor st Westminster, Md. 21157</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-1-82		23c. NAME OF CEMETERY OR CREMATORIAL Deer Park Cemetery			23d. LOCATION CITY OR TOWN Westminster COUNTY Carroll STATE Md.				
24. FUNERAL DIRECTOR NAME <u>Thomas D. Fletcher &amp; Son F</u>		25. ADDRESS 254 East Main Street Westminster, Md. 21157		26. DATE REC'D. BY REGISTRAR OCT 4 1982			25b. REGISTRAR'S SIGNATURE <u>John J. Carroll</u>				
BP											



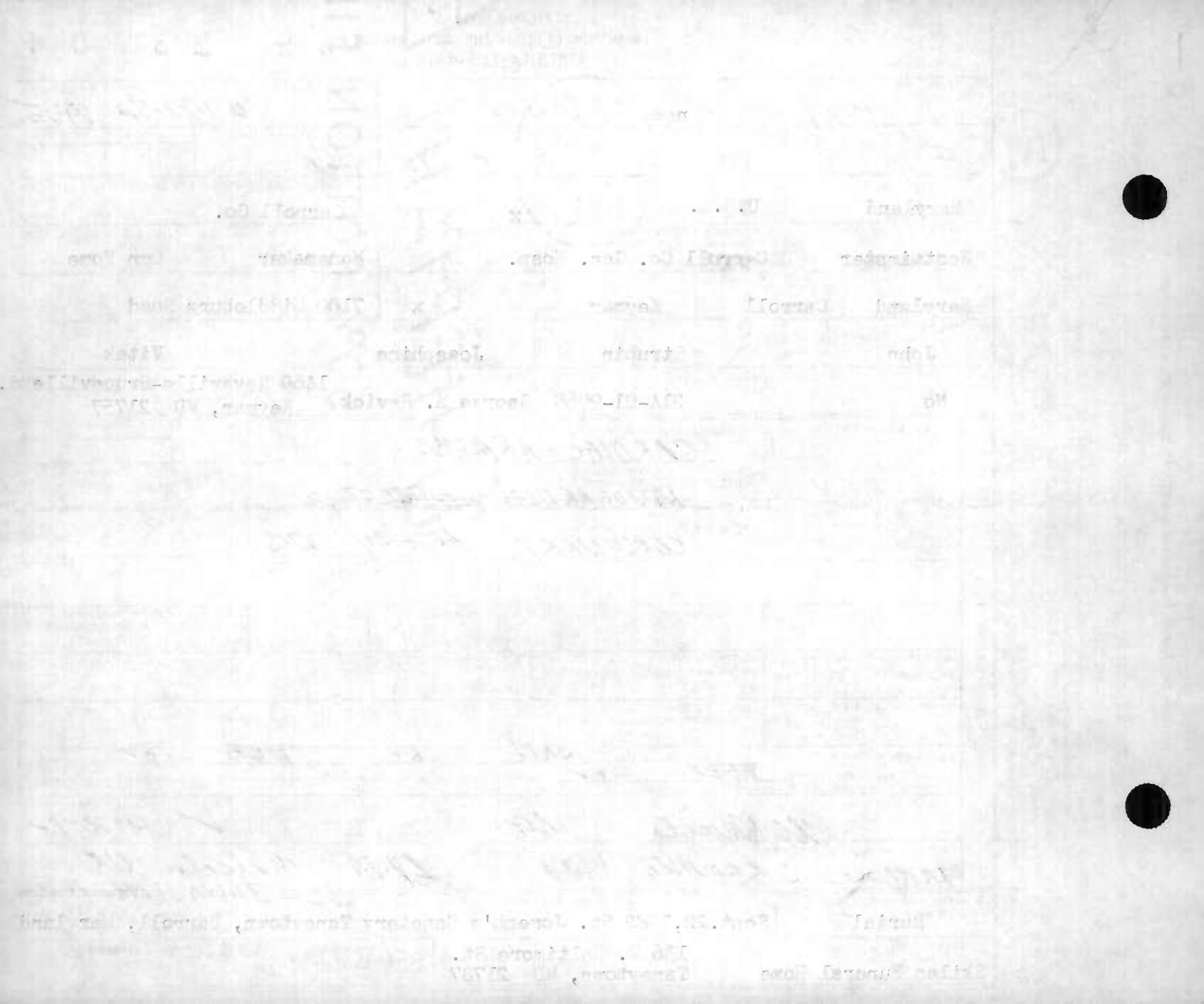
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical certification section should be completed.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	2	2	3	7	0	4
										REG. NO. 89-19-80 1905M						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
MARY			Anna Sevick			89-19-80			09	19	80	1905M				
3. SEX			4. RACE			5. DATE OF BIRTH			MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)				
F			W			6 5 96			86			IF UNDER 1 YEAR MONTHS DAYS				
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH				
Maryland			U.S.A.						Carroll Co.			Westminster				
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Carroll Co. Gen. Hosp.										Homemaker			Own Home			
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Maryland			Carroll			Keymar						7100 Middleburg Road				
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME										
John			Strubin			Josephine						Vitek				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. ADDRESS			19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No			214-01-9968			George A. Sevick			1460 Keysville-Bruceville Rd.			Keymar, MD 21757				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:																
IMMEDIATE CAUSE (a) <b>CARDIAC ARREST</b>																
4100 DUE TO, OR AS A CONSEQUENCE OF (b) <b>MYOCARDIAL INFARCTION</b>																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																
DUE TO, OR AS A CONSEQUENCE OF (c) <b>CORONARY ARTERY D.S.</b>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>JAN 19 80</b> to <b>Feb 19 80</b> , that (I) (we) last saw the deceased alive on <b>Feb 19 80</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <b>Malcom J. Sevilla</b>										DEGREE <b>MD</b>	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>9-20-82</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Malcom J. Sevilla MD</b>										22e. ADDRESS <b>1119C Malcolm Dr</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. CITY OR TOWN			COUNTY				
Burial			Sept. 22, 1982			St. Joseph's Cemetery			Taneytown			Carroll, Maryland				
24. FUNERAL DIRECTOR NAME			136 E. Baltimore St.			ADDRESS			25d. DATE REC'D. BY REGISTRAR			REGISTRAR'S SIGNATURE				
Skiles Funeral Home			Taneytown, MD 21787						SEP 23 1982			John J. Carroll				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in order to have the death certificate certified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 2 2 3 7 0 5					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
ALETHIA			R. Simcoe						9 30 82						2p M		
1. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS				
Female		White		MONTH 11 DAY 28 YEAR 00			81			MONTHS			DAYS HOURS MIN.				
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
Maryland		U.S.						Carroll									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Westminster		Carroll City Hospital										Clerk			Electric Manu.		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS							
Md.		Carroll		Lincolno						20915 Gunpowder Rd.							
14. FATHER'S NAME		FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
Charles		Rother			Rosa			217 03 3538			Kathryn Strong			some as above			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			16c. ADDRESS			17. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
No																	
18. CAUSE OF DEATH: (Enter only one cause per line for 18, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4100</b> PROBABLE myocardial infarction 3 hours																	
Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (c) <b>ASCVD</b>																	
DOUE TO, OR AS A CONSEQUENCE OF (b) <b>ASCVD</b>																	
DOUE TO, OR AS A CONSEQUENCE OF (c) <b></b>																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
												YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>9/30</b> 19 <b>82</b> to <b>9/30</b> 19 <b>82</b> , that (I) (we) last saw the deceased alive on <b>9/30</b> 19 <b>82</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Norman Goldstein M.D.</i>		22c. DEGREE										22d. DATE SIGNED <b>9/30/82</b>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Norman Goldstein</b>		22e. ADDRESS <b>218 Washington Heights Med Ctr Washington St., Md 21152</b>															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE <b>10-4-1982</b>			23c. NAME OF CEMETERY OR CREMATORIAL Pine Grove Cem.			23d. LOCATION CITY OR TOWN <b>Parkton, Balto., Md.</b>			23e. COUNTY STATE						
24. FUNERAL DIRECTOR NAME <i>J. P. Hartenstein</i>		ADDRESS New Freedom, Pa.			25a. DATE REC'D. BY REGISTRAR <b>OCT 13 1982</b>			25b. REGISTRAR'S SIGNATURE <i>John G. Conroy</i>									
BP _____																	
DHMH-16 50M 1/81 (VRA 15, 4)																	

•bM

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death.

**IMPORTANT:** If Item 2 is marked or Item 18 shows any injury or other traumatic event, the medical examiner must be consulted. If the injury or event is not life threatening, the medical examiner may be consulted by telephone. If the injury or event is life threatening, the medical examiner must be consulted in person. If the medical examiner is not available, the coroner or medical examiner's representative must be consulted. If the medical examiner is not available, the coroner or medical examiner's representative must be consulted in person.

MEDICAL CERTIFICATION

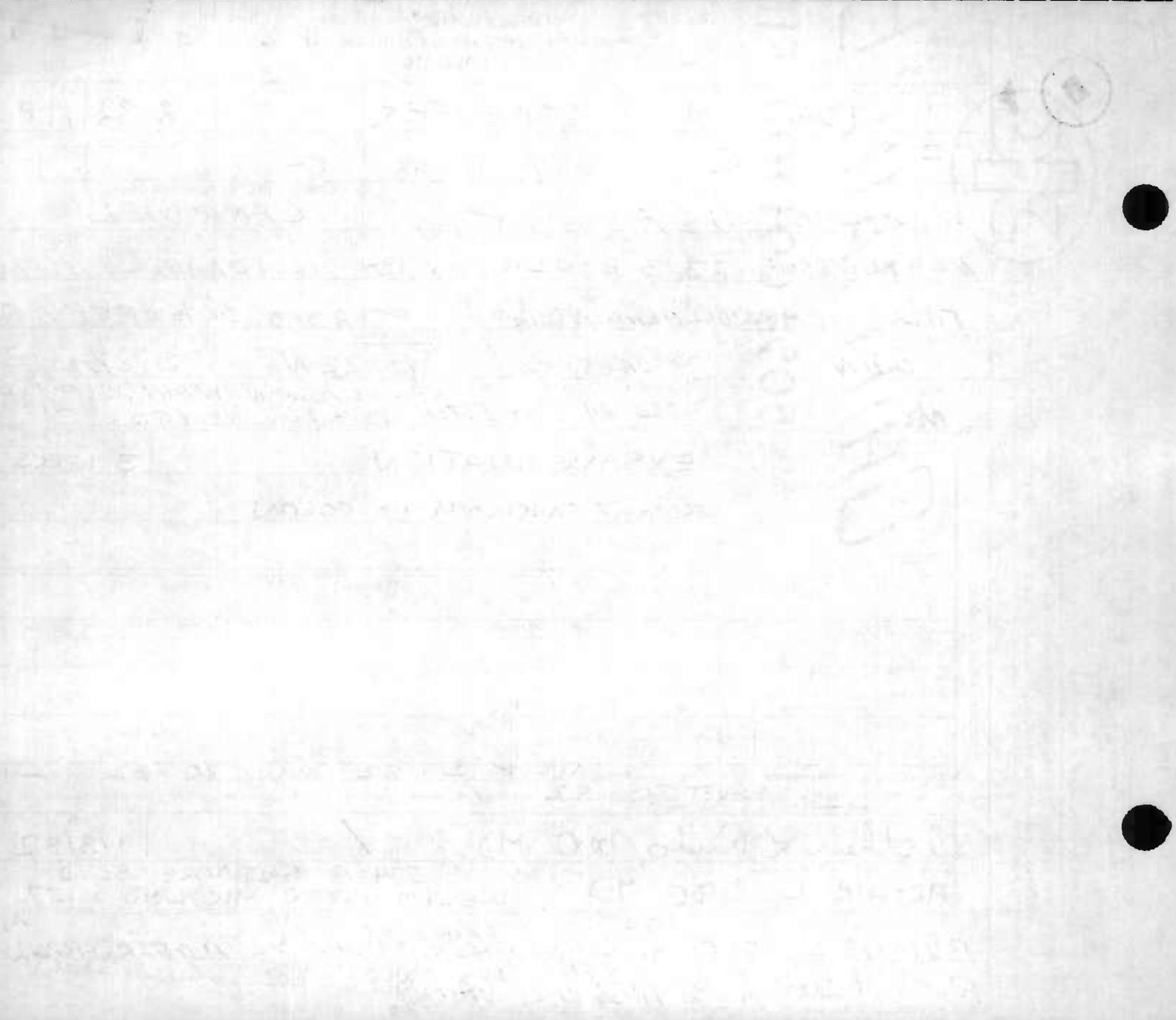
1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 2 2 3 1 0 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
IDA M STONESIFER								9	2	82	11 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
F		C		7 14 98			84			MONTHS	YEARS	HOURS	MIN.	
7b. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			CARRULL MD.				
MARYLAND USA														
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
NEWWINDSOR		2313 BOWERSOX RD		HOUSEKEEPER			HOUSEKEEPER							
13a. STATE		13b. COUNTY		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS							
MD.		CARROLL		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			2313 BOWERSOX RD							
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST				
		JOHN		STONESIFER	ELLEN					STONESIFER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
No		220-24-3320		ELTON			NEWWINDSOR, MD.			21776				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		IMMEDIATE CAUSE (a)			EXSANGUINATION						3 WEEKS			
1539		DUE TO, OR AS A CONSEQUENCE OF (b) PROBABLE CARCINOMA OF COLON												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from AUGUST 12, 1982, to AUGUST 20, 1982, that (I) (we) lost saw the deceased alive on AUGUST 20, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.														
22b. SIGNATURE		DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED						
Arthur L. Rudo, M.D.		MD									9/3/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			524-B BALTIMORE BLVD			WESTMINSTER, MARYLAND 21157						
ARTHUR L. RUDO, M.D.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL ESTATE		23d. LOCATION CITY OR TOWN		23e. DATE REC'D. BY REGISTRAR		MD				
BURIAL		1982 SEPT. 5,		JOHN LUTHER MILLER - WEST MINSTER CEMETERY		CITY OF TOWN		15 SEP 1982		COUNTY				
24. FUNERAL DIRECTOR (NAME)		24a. ADDRESS		24b. DATE		24c. SIGNATURE		24d. REGISTRAR'S SIGNATURE						
Richard Ludo		34 Main Street		VA.		15 SEP 1982		John Ludo						



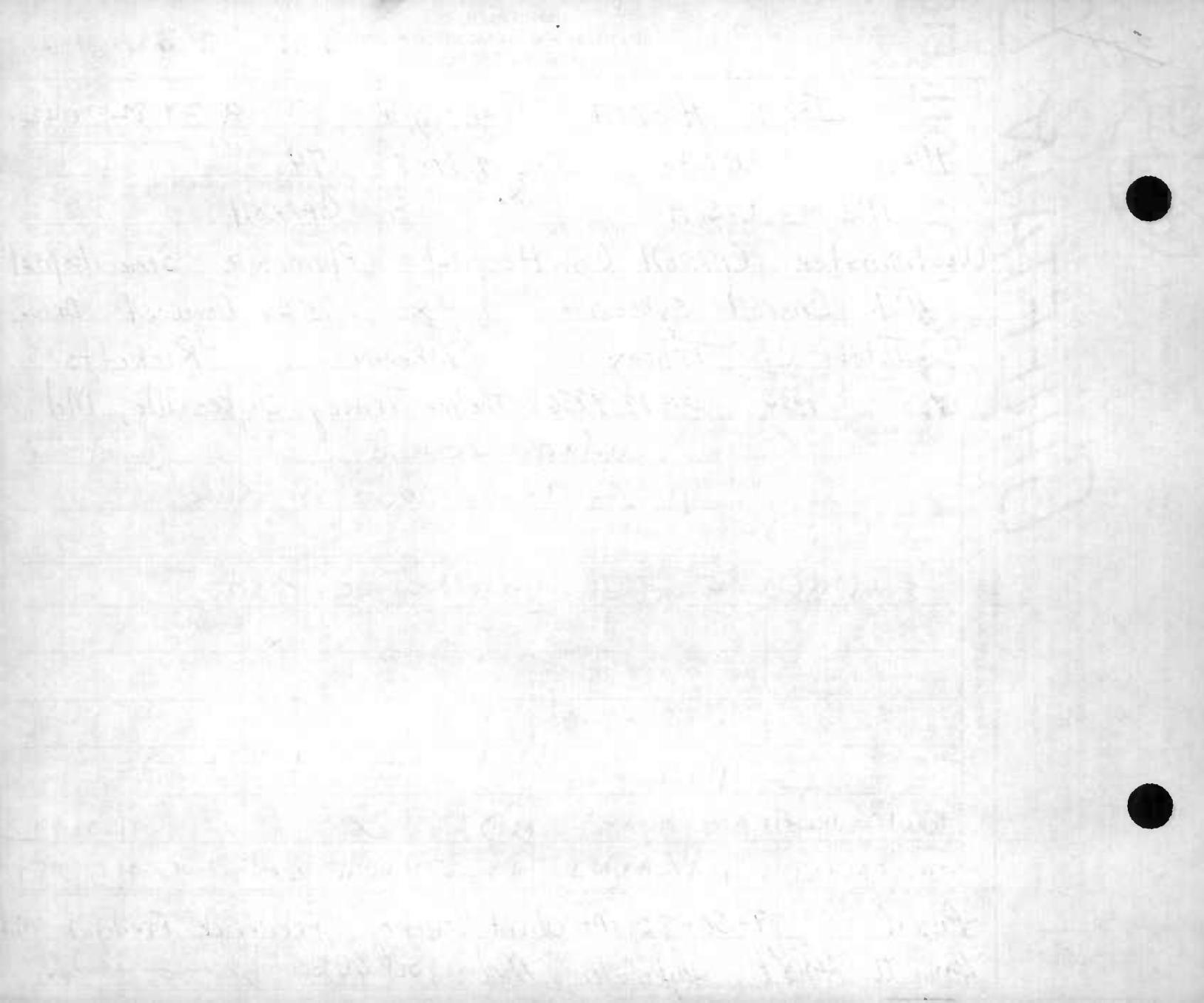
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial/cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 3 7 0 1					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
John Howard Tracey, Sr.						9-27-82			2042u						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.			
Male		White		Month Day Year			74			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Md.		U. S. A.					Carroll								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Westminster		Carroll Co. Hospital										Plummer		State Hospital	
13a. STATE		13b. COUNTY		13c. CITY, OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Md.		Carroll		Sykesville			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			7526 Dogwood Drive					
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME											
John C.		Tracey		Catherine						Ricketts					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
Yes		1924		213 18 9236			Thelma Tracey Sykesville Md.			Instant					
18. CAUSE OF DEATH (Enter only one cause per line for 1a, (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardiac arrest</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Altered Sclerotic Heart Disease</u> (c) <u></u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Emphysema; cerebrovascular accident.</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>8/1/91</u> to <u>9/27/82</u> , that (I) (we) last saw the deceased alive on <u>9/27/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Chitra Reddy Naganna</u>		22c. DEGREE <u>MD</u>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <u>9/27/82</u>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>CHITRA REDDY NAGANNA</u>		22e. ADDRESS <u>174 E. Main St. Westminster MD 21157</u>													
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT)		23b. DATE <u>9-30-82</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>Mt. Olivet Cemetery</u>			23d. LOCATION CITY TOWN <u>Frederick Frederick Md.</u>			COUNTY		STATE		
24. FUNERAL DIRECTOR NAME <u>Harry W. Haight</u>		ADDRESS <u>Sykesville, Md.</u>			25a. DATE REC'D. BY REGISTRAR <u>SEP 30 1982</u>			25b. REGISTRAR'S SIGNATURE <u>John J. Conroy</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of death.

IMPORT ANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 2 3 7 0 8	REG. NO.		
1. FOR STATE REGISTRAR			1. DECEASED NAME [TYPE OR PRINT] Carl David Traenker, Sr.						2a. DATE OF DEATH Sept. 20, 1982			2b. HOUR 7:03p M			
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR Sept. 14, 1937			6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE COUNTRY Penns.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County			MD.			
10. CITY OR TOWN OF DEATH Finksburg			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION [IF NOT IN HOSPITAL, GIVE STREET ADDRESS] 2405 Deer Park Road						12a. USUAL OCCUPATION Project Manager			12b. KIND OF BUSINESS OR INDUSTRY Poole & Kent Co.			
13a. STATE Md.			13b. COUNTY Carroll			13c. CITY OR TOWN Finksburg			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 2405 Deer Park Road			
14. FATHER'S NAME FIRST MIDDLE LAST Emil Ferdinand Traenker			15. MOTHER'S MAIDEN NAME Dorothy Elizabeth Blankley												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 138-28-3612			17. INFORMANT Grace C. Traenker			ADDRESS 2405 Deer Park Rd., Finksburg, Md. 21048						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1910</u> <u>glioma</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 years			
DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION 1981			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED @ hemispherical glioma						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>8/23</u> 19 <u>82</u> to <u>9/20</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>8/23</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <u>Norman Goldstein</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 9/21/82						
22d. PHYSICIAN'S NAME [TYPE OR PRINT] Norman Goldstein			22e. ADDRESS 218 Washington Heights Medical Westminster, Md. 21157												
23a. BURIAL, CREMATION, REMOVAL [SPECIFY] Cremation			23b. DATE Sept. 21, 1982			23c. NAME OF CEMETERY OR CREMATORIAL Westview Mem. Park			23d. LOCATION TOWN Baltimore, Maryland			COUNTY STATE			
24. FUNERAL DIRECTOR NAME <u>H. Edwards</u>			25a. DATE REC'D. BY REGISTRAR SEP 23 1982						25b. REGISTRAR'S SIGNATURE <u>J. L. Smith</u>						
ADDITIONAL INFORMATION															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 18 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												82	23	109		
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
LUELLA B. WALKER						9 4 82					0853	M				
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS		
FEMALE			WHITE			MONTH DAY YEAR 10 27 1894			87			MONTHS	DAYS	HOURS	MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			CARROLL COUNTY MD.				
MARYLAND			U. S. A.													
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
WESTMINSTER			CARROLL Co. GENERAL HOSPITAL			HOUSEWIFE										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			4914 SHAFFER MILL RD	
MARYLAND			CARROLL			MILLERS										
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	COOPER				
GEORGE					FOURMAN	EMMA			J.			4914 SHAFFER MILL RD				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. ADDRESS			MILLERS, MD.				
NO			214-74-5756			GEORGE H. WALKER										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
1590 IMMEDIATE CAUSE (a) RENAL FAILURE												HOURS				
DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA OF BOWEL												1 YEAR				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. MEDICAL CERTIFICATION			19b. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
									YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on			8/2 1982			to			9/4 1982							
above, (I) (we) (did) (did not) view the body after death.			9/4 1982													
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED							
Yvonne J. Bruce Jr.			MD									9/4/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. STATE				
BURIAL			SEPT 7 1982			BETHLEHEM-STELTZ CEM.			GLEN ROCK, PA			YORK COUNTY				
24. FUNERAL DIRECTOR (NAME)			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
J. Hartenstein, New Freedom, PA			17349			SEP 10 1982			J. Hartenstein							

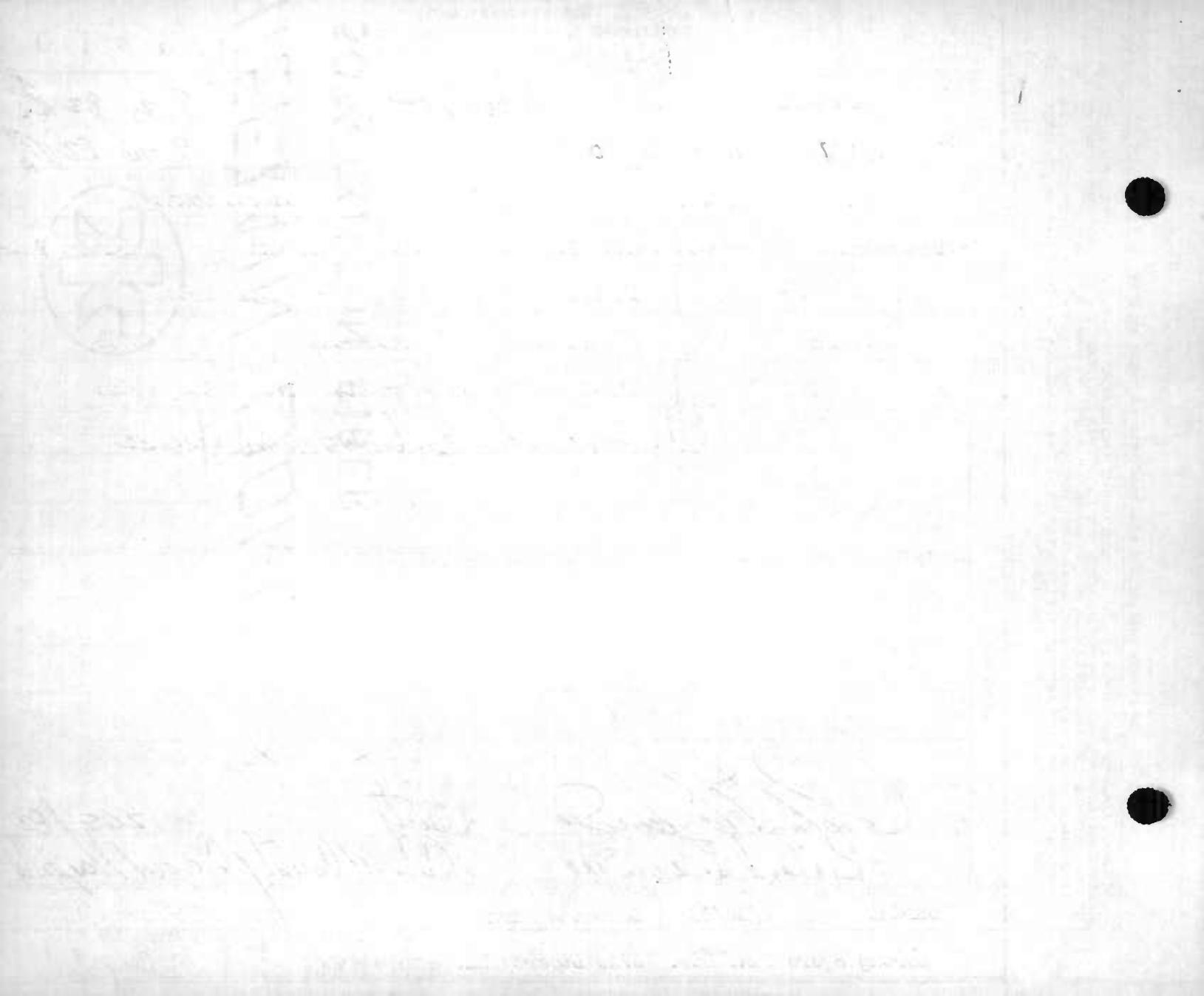


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 4 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2223110											
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH DAY YEAR								
Gustavius			W.			Wheeler						9 26 1982			10/29/82								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR						
Male		White		Oct. 5 21			60 yrs.			MONTHS		DAYS		HOURS		9 26 1982			11/29/82				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.														
MD.			U.S.A.																				
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY														
MD.			Carroll County General Hospital			Salesman			Hardware Fair														
13a. STATE MD.			13b. COUNTY Carroll			13c. CITY OR TOWN Winfield			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1700 Valley Drive												
14. FATHER'S NAME FIRST Gustavius			MIDDLE			LAST Wheeler			15 MOTHER'S MAIDEN NAME FIRST Katherine			MIDDLE			LAST Weber								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. WW2			17. INFORMANT Laura Wheeler			ADDRESS 1700 Valley Drive														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Obtuse atherosclerotic Cardiovascular Disease</i>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
4292 Conditions, if any, which goe rise to immediate cause (a) stating the under- lying cause last.																							
DUE TO, OR AS A CONSEQUENCE OF (b) <i></i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>																							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?																	
						YES <input type="checkbox"/> NO <input type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE <i>Richard J. Byers</i>															TITLE (SPECIFY) M.D. <i>Richard J. Byers</i>			MEDICAL EXAMINER			DATE SIGNED <i>26 Sep 82</i>		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS <i>Carroll County General Hospital</i>																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 9/29/82			23c. NAME OF CEMETERY OR CREMATORIAL Lorraine Park			23d. LOCATION CITY OR TOWN Woodlawn			COUNTY Baltimore			STATE MD.								
24. FUNERAL DIRECTOR NAME			ADDRESS Loring Byers Fun. Dir. 8728 Liberty Rd.			25a. DATE REC'D. BY REGISTRAR SEP 28 1982			25b. REGISTRAR'S SIGNATURE <i>Carroll J. Conner</i>														



1

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

2 2 2 3 7 1 1

REG. NO. 23711

1- STATE REGISTRAR			2a. DATE KNOWN <input checked="" type="checkbox"/> MONTH 9 DAY 1982 YEAR 1982										2b. HOUR 2:17			
1. DECEASED NAME (TYPE OR PRINT)			FIRST Paul			MIDDLE M.			LAST Zechman			2c. DATE PRONOUNCED DEAD 9 19 1982			2d. HOUR 2:17 P.M.	
3. SEX M		4. RACE WHITE		5. DATE OF BIRTH MONTH OCT YEAR 1970		6. AGE (IN YEARS LAST BIRTHDAY) 5 YRS.		7. IF UNDER 1 YR. MONTHS		IF UNDER 24 HRS. HOURS		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County, MD.		
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		11. CITIZEN OF WHAT COUNTRY? USA		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRE-SCHOOL 12b. KIND OF BUSINESS OR INDUSTRY CHESAPEAKE ESTATES RD #4 ESTATES												
13. CITY OR TOWN OF DEATH Westminster		14. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital		15. FATHER'S NAME FIRST RANDY MIDDLE ZECHMAN LAST JANET		16. MOTHER'S MAIDEN NAME FIRST MOSLER MIDDLE										
17. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE PA. COUNTY ADAMS TOWNSHIP		18. CITY OR TOWN ADAMS NEW OXFORD		19. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. STREET ADDRESS RD #4 PA.										
21a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		21b. SOCIAL SECURITY NO. NONE		21c. INFORMANT CHESAPEAKE ESTATES RD #4 PA.		22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9060 IMMEDIATE CAUSE (a) <b>Multiple Dog Bites</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR <input checked="" type="checkbox"/> MONTH DAY YEAR 1:30 P.M. 9 19 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject was attacked by dog		21d. LOCATION STREET 1819 Mayberry Rd., CITY OR TOWN Westminster, Carroll Co., COUNTY STATE Md.										
22a. I certify that I took charge of the remains described above, held an death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion														
ACTUAL SIGNATURE <i>Dennis F. Smyth, M.D.</i>		TITLE (SPECIFY) Assistant						DATE SIGNED 9-20-82								
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.		ADDRESS 111 Penn Street														
23a. BURIAL, CREMATION, REMOVAL (IF ANY) Burial		23b. DATE 23, SEPT 1982		23c. NAME OF CEMETERY OR CREMATORIUM ST. MARY'S CEMETERY		23d. LOCATION CITY OR TOWN RUN COUNTY SILVER SPRINGS STATE MD.										
24. FUNERAL DIRECTOR NAME <i>Richard L. Smith</i>		ADDRESS 34 M. St. Ave.		25a. DATE REC'D. BY REGISTRAR 17340 SEP 24 1982		25b. REGISTRAR'S SIGNATURE <i>John J. Cahill</i>										
BP		ADDRESS 17340 SEP 24 1982														
DHMH - 17 (VR A15 ME (5))																
20M 4/22																

